

## TABLE OF CONTENTS

I.	Introduction .....	1
II.	Definitions .....	1
III.	LME Requirements For Participation .....	4
A.	Divesture .....	4
B.	Accreditation.....	4
C.	Financial .....	5
1.	Financial Resources .....	5
2.	Financial Statements .....	5
D.	Legal Actions .....	5
E.	Guardianship .....	5
F.	Self-referral Prohibition.....	6
G.	Medical Malpractice/Liability Insurance .....	6
H.	Automation .....	6
I.	Conflict of Interest .....	7
J.	Services Billed through the LME .....	7
IV.	Staffing Requirements.....	7
A.	Minimum Requirements .....	7
B.	Special Review Team.....	8
C.	Organizational Structure.....	8
D.	Hiring and Training .....	8
E.	Staff Qualification Verification .....	9
F.	Staffing Requirements for Adverse Action Determinations .....	10
G.	Subcontracts .....	10
V.	Provider Assistance .....	10
A.	Call Center .....	10
B.	Provider Representative .....	11
C.	Provider Inquiry/Complaint Resolution Process .....	11
D.	Provider Assistance Reports .....	12
VI.	Utilization Management.....	12
VII.	Utilization Review Components .....	13
A.	Medical Necessity .....	13
B.	Medical Necessity Criteria .....	14
C.	EPSDT .....	15
D.	Residential Child Care Treatment (Levels I through IV) Facility Provider Enrollment Data .....	15
E.	Service Authorization Request Documentation .....	16
F.	Receipt of Service Authorization Requests .....	18
G.	Timeframes for Response to Initial Requests for Service Authorizations.....	18
1.	Emergent/Urgent .....	18
2.	Routine .....	19
3.	CAP/MR-DD and Targeted Case Management.....	19
4.	Criterion 5 .....	19
5.	Out-of-state Services .....	19
6.	EPSDT .....	19
H.	Timeframes for Response to Requests for Service Re-authorizations.....	19

I.	Timeframes for Response to Requests for Retrospective Reviews .....	19
J.	Recipient Eligibility .....	19
1.	Eligibility File .....	20
2.	Cross Referenced Medicaid Identification Numbers.....	20
K.	Provider Eligibility .....	20
VIII.	Types of Utilization Reviews .....	21
A.	Initial Reviews .....	21
B.	Concurrent Reviews for Re-authorization of Service.....	21
C.	EPSDT Reviews .....	22
D.	Requests for Non-covered Services.....	22
E.	Retrospective Reviews .....	22
1.	Medicaid Eligibility .....	22
2.	Provider Transfers .....	23
F.	Special Team Reviews .....	23
G.	Quality Assurance Reviews.....	23
1.	Quality Assurance Reviews .....	23
2.	Quality of Care Complaints.....	24
IX.	Authorization Process .....	24
A.	Outpatient Behavioral Health Services.....	24
1.	Initial Authorization Reviews.....	24
2.	Concurrent Reviews for Re-authorization.....	27
B.	Enhanced (Community Intervention Services) Behavioral Health Services .....	29
1.	Initial Authorization Reviews.....	29
2.	Concurrent Reviews for Re-authorization.....	31
C.	Inpatient Behavioral Health Services, Including Psychiatric Residential Treatment Facility Services .....	33
1.	Initial Authorization Reviews.....	33
2.	Concurrent Reviews for Re-authorization.....	36
D.	Residential Child Care Treatment (Levels I through IV) Facility Services and Therapeutic Foster Care.....	39
1.	Initial Authorization Reviews.....	39
2.	Concurrent Reviews for Re-authorization.....	41
E.	Criterion 5 Services .....	43
F.	CAP/MR-DD and Targeted Case Management .....	44
1.	Initial Authorization Reviews.....	44
2.	Concurrent Reviews for Re-authorization.....	46
G.	Out-of-State Services .....	49
H.	Services Approved through EPSDT Reviews.....	50
I.	Services Approved through Retrospective Reviews.....	51
X.	Disposition of Authorization Requests .....	52
A.	Approval .....	52
B.	Pended Requests.....	53
C.	Revisions to the Original Request Resulting in a Change in Services .....	53
D.	Administrative Denials .....	54
1.	Missing or Incorrect Information .....	54
2.	Duplicate Requests.....	55
3.	Requests for Services that Are Currently Authorized to Another Provider .....	56
E.	Denial/Reduction .....	56

XI.	Notification of Adverse Actions .....	57
A.	Recipient Notices .....	57
B.	Notice Format.....	58
C.	Date of Notification .....	58
D.	Tracking Notifications .....	58
E.	Notification Audits.....	59
XII.	Hearings and Appeals.....	59
A.	Filing for a Hearing with the Office of Administrative Hearings .....	59
B.	Hearing Process.....	59
C.	Responsibilities of LME for Appeals and Hearings.....	60
XIII.	Maintenance of Service.....	61
XIV.	LME Performance Standards.....	61
A.	Objectives.....	61
1.	Quality Improvement Plan .....	61
2.	Clinical Care Criteria.....	61
3.	Monitoring .....	62
B.	Performance Measures for DMA.....	62
1.	Treatment Patterns .....	62
2.	Erroneous Decisions.....	62
3.	Records Review.....	62
4.	Timeline for Review of Services .....	62
5.	Review of Inpatient Services .....	63
6.	Electronic Submissions.....	63
7.	Notification .....	63
8.	Adverse Notification.....	64
9.	Telephone Access .....	64
10.	Provider Relations .....	64
11.	Retrospective Reviews .....	64
12.	Quality Assurance Reviews .....	64
13.	Audits.....	65
14.	Clinical Care Manager Certification .....	65
XV.	Privacy and Security .....	65
A.	Records and Confidentiality.....	65
B.	HIPAA Standards .....	65
C.	N.C. Identity Theft .....	65
D.	Mishandled Protected Health Information .....	66
E.	Business Associate Requirements.....	66
XVI.	Confidentiality.....	66
XVII.	Security .....	67
A.	Computer Laptops .....	67
B.	Electronic Mail .....	68
C.	Configuration .....	68
D.	Firewall/Mail Relay .....	68
E.	Intrusion Detection System (IDS)/Intrusion Prevention System (IPS) .....	68
F.	Other Security Requirements .....	69
XVIII.	Statewide Architecture .....	69

XIX.	Disaster Recovery .....	69
XX.	Data Processing .....	70
A.	Overview .....	70
B.	Prior Approval Process .....	70
1.	Daily PA File .....	70
2.	Overlapping Authorization Dates .....	71
3.	Summary File .....	71
C.	Data Collection .....	72
D.	Front-end Editing .....	72
E.	Data Ownership .....	72
XXI.	Reporting .....	72
A.	Ad Hoc Reports .....	73
B.	Quarterly Reports .....	73
1.	Summary Report for Notifications for Quality of Care Complaints .....	73
2.	Staff Qualification Verification .....	73
3.	Significant Trends .....	73
4.	Compliance Reports .....	73
C.	Monthly Report on Adverse Determination Letter Audit .....	73
XXII.	Invoicing .....	73
A.	Submitting Invoices .....	73
B.	Issue Resolution .....	75
C.	Reduction of Reimbursement to LME Based on Performance .....	75
D.	Payment .....	75
XXIII.	Other Requirements .....	76
A.	Meetings .....	76
B.	Contract Administrator .....	76
C.	Travel .....	76
D.	Testing .....	76
Attachments .....		
A.	Staff Credentialing Reporting Form .....	77
B.	Residential Child Care Treatment (Levels I through IV) Facility Provider Enrollment Data Spreadsheet .....	78
C.	Service Request Form .....	79
D.	Criterion 5 Service Needs/Discharge Planning Status Form .....	80
E.	Certifications of Need for Psychiatric Inpatient Stays for Recipients under the Age of 21 .....	81
F.	Notification of Quality of Care Memo Template .....	83
G.	Service Authorization Timeline .....	84
H.	Clinical Review Form .....	88
I.	EPSDT Request Clinical Review Form .....	90
J.	Authorization Notification Letter Templates .....	92
K.	Discharge from Treatment Form .....	127
L.	Hearing Request Form .....	128
M.	Medicaid Recipient Fair Hearing Timeline .....	130
N.	HIPAA Breach Report Form .....	131
O.	LME PA Authorization Inbound File Layout .....	132
P.	LME PA Authorization Outbound File Layout .....	135
Q.	PA Authorization Error Codes .....	138
R.	Weekly Summary Inbound File Layout .....	140

S.	Weekly Summary Outbound File Layout .....	141
T.	Weekly Summary Error Codes .....	142
U.	Quality of Care Incident Report .....	143
V.	Invoice Report Format .....	144

## I. INTRODUCTION

Medicaid is a health insurance program for low-income individuals and families who cannot afford health care costs. Medicaid serves low-income parents, children, seniors, and people with disabilities. The N.C. Department of Health and Human Services (NC DHHS) is responsible for administering the State's Medical Assistance Program (Medicaid, Title XIX) throughout the state. The Division of Medical Assistance (DMA) is the section of NC DHHS that manages the Medicaid program in the State of North Carolina and is specifically tasked with the daily logistics of delivering services to eligible participants. DMA has a budget of over \$9 billion, processing over 72 million claims per year.

NC DHHS, in response to General Assembly Session Law 2008-10 (HB 2436, Section 10.15(x)), is designated to oversee the implementation of this legislation that requires the Local Management Entities (LMEs) to provide utilization review of Medicaid-covered mental health, developmental disability, and substance abuse treatment services provided in North Carolina. The purpose of this document is to outline and define the requirements the LMEs must meet to be approved to provide utilization review services. The purpose for meeting these requirements is to assure Medicaid billing by endorsed providers is appropriate and justified and that regulations required in the Medicaid State Plan per 42 CFR 456 are met.

## II. DEFINITIONS

**Adverse Determination** – A determination to deny, terminate, suspend, or reduce Medicaid-covered services.

**ASAM** – American Society of Addiction Medicine.

**Appropriate Services** – Services deemed appropriate for authorization are those services which meet the criteria for medical necessity.

**CAP/MR-DD** – Community Alternatives Program for Individuals with Mental Retardation/Developmental Disabilities.

**CON** – Certificate of Need.

**Concurrent Review** – After the LME has initially authorized a service, concurrent review follows the treatment as it is occurring and makes determinations about the medical necessity of continued care.

**Consumer** – An individual child or adult who receives mental health, developmental disability or substance abuse treatment services.

**Covered State Medicaid Plan Services** – Services covered under the North Carolina State Medicaid Plan. These are the service requests that will be reviewed by the LME.

**Criterion 5** – Criterion 5, as stated in 10A NCAC 22O.0113, is non-acute hospital service used as a transition service when, and only when, a recipient under the age of 17 is ready for discharge from inpatient care and there is a clear absence of appropriate community-based services for the recipient to return to.

**CPT** – (Physician’s) Current Procedural Terminology Codes. Nationally standardized service definitions coded by the American Medical Association.

**CMS** – Centers for Medicaid and Medicare Services.

**DHHS** – Department of Health and Human Services.

**DIRM** – the DHHS Division of Information Resource Management.

**DMA** – Division of Medical Assistance.

**DMH** – Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

**Early Periodic Screening, Diagnosis and Treatment (EPSDT) Review** – Defined as a review for services for recipients under the age of twenty-one (21) when the service(s) requested exceed unit or visit limitations or age exclusions as delineated in the service definitions or clinical coverage policies for the service or the requested service is not included in the North Carolina State Medicaid Plan but is coverable under 1905(a) of the Social Security Act..

**“Hands On”** – Clinical staff with the appropriate credentials must personally review each prior approval request. Automated approval without review by clinical staff is not acceptable.

**HCPCS** – HCFA Common Procedural Coding System. National codes assigned to the previously used state-created codes that are used for counseling and rehab option services.

**HIPAA** – Health Insurance Portability and Accountability Act of 1996.

**LME** – Local Management Entity.

**Maintenance of Service** – If an applicant or recipient currently receiving services requests a hearing before the effective date of an adverse determination, they will continue to receive Medicaid services at the level provided on the day immediately preceding the adverse determination or the amount requested, whichever is less.

**Medical Necessity** – See **Section VII.A.** for a definition of medical necessity.

**Non-covered State Medicaid Plan Services** – Services covered under 1905(a) of the Social Security Act but not covered by the North Carolina State Medicaid Plan. These requests will be reviewed by the LME and forwarded to DMA for final review and decision.

**Outpatient Behavioral Health** – Behavioral health benefits including assessment, treatment (individual medical evaluation and management, including medication management, individual and group therapy, behavioral health counseling), family therapy, and psychological testing provided by direct-enrolled behavioral health practitioners for recipients of all ages.

**Piedmont Behavioral Health** – The Piedmont Cardinal Health Plan (PCHP) administers all Medicaid-covered behavioral health services, substance abuse services, and services to persons with developmental disabilities in Cabarrus, Davidson, Rowan, Stanly, and Union counties. Services are also provided to mentally retarded/developmentally disabled individuals through the new Piedmont Innovations program, which replaces the Community Alternatives Program for MR/DD in these five counties.

**Person Centered Plan** – The person centered plan is a document that captures the services and natural supports required to meet the recipient's needs.

**Protected Health Information** – Defined in 45 CFR 160.103.

**PRTF** – Psychiatric Residential Treatment Facility.

**PI** – DMA Program Integrity Section.

**Prior Approval** – The process undertaken for the purpose of determining the appropriateness of a service for an individual before the service is delivered.

**QIO** – Quality Improvement Organization.

**Quality Assurance Monitoring** – Review of all Medicaid covered services (excluding those services covered by other Program Integrity reviews).

**Representative** – For the purpose of an appeal of an adverse decision, the consumer may designate an individual to represent him/her in the process of appeal.

**Retrospective Review** – Reviews conducted after the service was rendered as a result of retroactive Medicaid eligibility when the service has been provided before the individual is determined to be Medicaid eligible.

**Service Provider** – The entity that is enrolled by DMA to provide medically necessary Medicaid covered services.

**Special Team Review** – Reviews requested by the State and conducted onsite to evaluate the needs of an individual or to monitor a program facility.

**State** – North Carolina.

**State Business Day** – Monday through Friday, 8:00 am through 5:00 pm, Eastern Standard Time with the exception of State Holidays as defined by the Office of State Personnel.

**Targeted Case Management (TCM)** – Case management is direct service designed to gain access for the recipient to medical, social, educational and other services. It consists of assessment, development of a care plan, referral and linkage to services, and monitoring and follow-up to assure service delivery and health safety of the recipient.

**Treatment Plan** – A plan of care, including person centered plans, based on comprehensive assessment, developed in partnership with an individual (or in the case of a child, the child's family) that outlines services to be provided to an individual.

**UM** – Utilization Management.

**UR** – Utilization Review.

### III. LME REQUIREMENTS FOR PARTICIPATION

#### A. Divestiture

The LME must be fully divested of direct service provision before performing utilization management and utilization review for Medicaid-covered services. The LME **must not** provide any Medicaid reimbursable services.

#### B. Accreditation

The LME must be nationally accredited or able to demonstrate that an acceptable application for accreditation has been submitted to a nationally accredited body.

Evidence of a formal relationship as of December 31, 2008, with an approved accrediting body must be provided with the goal of achieving national accreditation by December 31, 2009.

Accreditation with any one of the following four national accrediting bodies is acceptable until January 1, 2012.

- National Committee for Quality Assurance (NCQA)
- Utilization Review Accreditation Commission (URAC)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Council on Accreditation (COA)
- Council on Quality and Leadership (CQL)

By January 1, 2012, the LME must be accredited by NCQA or URAC to be eligible to perform or continue to perform Medicaid utilization management and utilization reviews.

The LME is required to attain Quality Improvement Organization (QIO) status with the Centers for Medicare and Medicaid Services. QIO-like entities must

- meet the requirements in Section 1152 of the Social Security Act and 42 CFR 475 and perform review functions specified under Section 1154 of the Social Security Act related to the performance of medical necessity and quality of care review
- be physician-sponsored
- be able review cases and analyze patterns of care related to medical necessity and quality review
- have at least one individual who is representative of consumers on its governing body
- not be a health care facility, health care facility affiliate, or health care association

Refer to

[http://www.cms.hhs.gov/QualityImprovementOrgs/03\\_HowtoBecomeaQIO.asp#ToPOfPage](http://www.cms.hhs.gov/QualityImprovementOrgs/03_HowtoBecomeaQIO.asp#ToPOfPage) for additional information.

**C. Financial****1. Financial Resources**

The LME must have the financial resources to meet all of the requirements for the provision of Medicaid utilization management and utilization review. No Medicaid start up funding is available.

**2. Financial Statements**

The LME must provide copies of the most recent two (2) years of independently certified audited financial statements of the organization. Audits should include: an opinion of a certified public accountant; a statement of revenue and expenses; a balance sheet; a statement of cash flows; and management letters. If the organization is too new to have audited financial statements, the LME shall attach copies of audited financial statements from each of the principal entities involved with the plan.

**D. Legal Actions**

If there have been any legal actions taken within the last two (2) years, or any legal actions pending against the LME, give a brief explanation and the status of each action.

The LME shall submit to DMA any information on any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent of the applicant who has been found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in Section 435.03, F.S. The LME shall not contract with an applicant that has an officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the applicant, who has committed any of the listed offenses. In order to avoid a determination that the proposal is non-responsive, the LME must submit a corrective action plan, acceptable to DMA, that ensures that such person is divested of all interest and/or control and has no role in the operation and management of the LME.

The LME must provide the requested information or attest that no officer, director, agent, managing employee, or owner of stock in excess of five percent (5%) of the LME has committed any of the listed offenses. The LME must further attest that it will promptly notify DMA at any time it becomes aware of such an occurrence.

The State reserves the right to reject a proposal from an LME who has had a legal judgment made against one or more of such persons if the judgment made would materially affect the LME from performing its responsibilities under the contract.

**E. Guardianship**

The LME cannot act as a recipient's legal guardian. Guardianship must be transferred to another appointed individual or entity as determined by the clerk of superior court.

**F. Self-referral Prohibition**

As mandated by NCGS 90-406, a health care provider must not make any referral of a patient to any entity in which the health care provider or group practice or any member of the group practice is an investor or may receive financial gains.

No invoice or claim for payment may be submitted by any entity or health care provider to any individual, third-party payer, or other entity for designated health care services furnished pursuant to a referral prohibited under NCGS 90-406. If any entity collects any amount pursuant to an invoice or claim presented in violation of NCGS 90-406, the entity must refund such amount to the payor or individual, whichever is applicable, within ten (10) working days of receipt.

Any health care provider or other entity that enters into an arrangement or scheme, such as a cross-referral arrangement, that the health care provider or entity knows or should know is intended to induce referrals of patients for designated health care services to a particular entity and that, if the health care provider directly made referrals to such entity, would constitute a prohibited referral under NCGS 90-406, shall be in violation of this law.

**G. Medical Malpractice/Liability Insurance**

During the term of the Contract, at its sole cost and expense, and through an insurance company or through a program of self-funded insurance, the LME must maintain professional liability insurance for itself and its professional staff with limits of at least (\$1,000,000) per occurrence and at least (\$3,000,000) in the aggregate.

The LME must furnish to DMA certificates evidencing this insurance coverage prior to commencing work and prior to the issuance of a purchase order. All certificates of insurance shall provide that the insurance company shall give DMA thirty (30) days written notice prior to cancellation or any change in the stated coverage of any insurance. The LME's insurance carrier must provide DMA with a waiver of subrogation for all policies.

**H. Automation**

The LME must have an automated system to capture and track service request information for utilization management and prior approval. The capability must exist to extract information from this system in a fixed length flat file with variable length fields and transmit it via secured FTP to the Fiscal Agent for prior approval processing and data reporting.

The system must be accessible remotely by DMA.

The LME must offer service providers the ability to check the status of their service request via a secured web connection.

The LME must be able to capture all documentation as outlined in this document in an electronic file. This includes the service request, supporting documentation, and all contacts made with the client via phone or mail and the outcome of the contacts. If documentation is only available in paper hard copy, the LME must have the ability to make an electronic image for immediate storage.

All service requests must be kept in an unalterable format to include a time/date-stamped field for integrity and audit purposes.

**I. Conflict of Interest**

The LME must not authorize services to be provided by any person who is also employed by the LME. The LME must not show favoritism to any provider and must avoid biased referral patterns.

**J. Services Billed Through the LME**

Direction on services that are currently billed through the LME will be provided at a later date.

## **IV. STAFFING REQUIREMENTS**

**A. Minimum Requirements**

The LME must, at a minimum, employ or contract with the following professional staff:

- A full-time Medical Director holding an unencumbered N.C. Medical License who is board certified in psychiatry. This position may not be divided among two or more individuals.
- A full-time Contract Manager who has a clinical background and who will coordinate Utilization Management with DMA.
- A full-time Director of Information Management Systems with a minimum of two (2) years experience in data management for a large health care contract covering a minimum of 100,000 lives.
- A full-time employee whose duties include being the Quality Improvements Manager.

The LME must, at a minimum, employ or contract with following clinical staff:

- A psychiatrist holding an unencumbered N.C. Medical License who is board certified or board eligible in child psychiatry.
- A physician holding an unencumbered N.C. Medical License who is board certified or board eligible in the American Society of Addiction Medicine (ASAM).
- A sufficient number of staff holding unencumbered N.C. Medical licensure or certification to support the functions described in this policy with expertise in each of the population groups serviced by Medicaid service in the LME catchment area.
- At least one staff must be available for each population group served.
  - ◆ Staff must be available who have special expertise with children and the elderly and have received training in cultural competency specific to key ethnic groups within their community.
  - ◆ Staff conducting CAP/MR-DD service authorization reviews or other developmental disability services reviews must meet the criteria for a qualified professional in developmental disabilities with a Bachelor's Degree in Human services and two (2) years experience with the relevant population.
  - ◆ Staff reviewing service authorization reviews for individuals with co-occurring disorders must have an advanced degree in one area and two (2) years experience in working with the co-occurring disorder.

- The following clinical staff who meet the criteria indicated in 10A NCAC 27G.0104 must review service authorizations for mental health services:
  - ◆ Licensed Psychologists
  - ◆ Licensed Psychological Associates
  - ◆ Licensed Professional Counselors
  - ◆ Licensed Marriage and Family Therapists
  - ◆ Licensed Clinical Social Workers
  - ◆ Nurse Practitioners who are certified as an Advanced Practice Psychiatric Nurse Practitioner
  - ◆ Certified Clinical Nurse Specialists in Psychiatric Mental Health Advance Practice
  - ◆ Certified Clinical Supervisors
  - ◆ Certified Clinical Addictions Specialists
- The following clinical staff who meet the criteria indicated in 10A NCAC 27G.0104 must review service authorizations for substance abuse treatment services:
  - ◆ Certified Clinical Supervisor
  - ◆ Licensed Clinical Addiction Specialist
  - ◆ Certified Substance Abuse Counselor
- The following clinical staff must review service authorizations for CAP/MR-DD waiver services:
  - ◆ A Qualified Developmental Disability Professional with a Bachelors degree in the human services field and a minimum of two (2) years experience with mental retardation/developmental disability experience.
  - ◆ A Registered Nurse, or a staff nurse with a Bachelors of Science in Nursing degree or a Masters of Science in Nursing degree, with a minimum of two (2) years experience with mental retardation/developmental disabilities.

**B. Special Review Team**

The LME must be able to comprise a Special Review Team to respond to requests from DMA to perform special team evaluations. The team must be comprised of a Ph.D. psychologist and a professional licensed or certified practitioner with expertise relevant to the disability of the individual for whom services are being reviewed (see **Section VIII.F.**).

**C. Organizational Structure**

The LME must specify the numbers of different professional staff that will be used to carry out the performance standards of the Medicaid utilization management and utilization review. The professional who will be assigned the responsibility for operational performance must be specified together with his/her resume.

**D. Hiring and Training**

All staff must be hired and trained to perform utilization management functions and in all aspects of the LME's utilization management operations no later than May 15, 2009. For clinical staff, the LME will ensure a working knowledge of person centered planning and service definitions, due process procedures, and EPSDT. Additional training for the utilization management staff will be provided by the LME as procedures and work flow changes occur.

The LME will submit reports of all staff trainings as requested. This report, when requested, will include dates of training, the trainers and their credentials, subject matter covered, and staff in attendance. The LME must submit the report to the DMA's Contract Administrator and keep on file a plan for on-going staff training pertinent to:

- child and adult mental health
- developmental disabilities
- substance abuse
- disabilities caused by traumatic brain injury
- co-occurring disabilities
- due process
- EPSDT
- person centered planning
- service definitions and clinical coverage policies
- medical necessity criteria
- all procedures and processes outlined in this document

**E. Staff Qualification Verification**

The LME must obtain and keep on file all relevant licenses and certifications of its practitioners. The LME must assure that licensure and certification is current.

Credentials must be provided by the LME to DMA for newly hired professional and clinical staff and then quarterly thereafter for all staff currently employed or contracted by the LME to provide utilization management functions.

The LME must report the credentialing information to DMA using the Staff Credentials Reporting Form (see **Attachment A**). The following information must be provided to DMA to allow for verification of the clinical staff's credentials:

- Licensure and certification documentation including, but not limited to
  - ◆ N.C. Licensure by the appropriate board or other licensing body.
  - ◆ Valid DEA or CDS certification, if applicable.
  - ◆ Board certification or eligibility, if the practitioner states that he/she is board certified or eligible on the application.
- Documentation of hospital privileges for individual or group practitioners providing hospital coverage, if applicable.
- Liability coverage in the amount required for participation.
- Malpractice and sanction history.
- Results of review of criminal background check for providers, owners and affiliates with five percent (5%) or more ownership.
- Results of review of individual clinical staff background checks, regardless of location.
- Assurance that provider is not excluded from participation by Medicare by the U.S. Office of Inspector General.

If the status of the LME's practitioners changes during the contract term, including loss of license or sanction, the LME must immediately inform DMA's Contract Administrator and suspend the employee's review functions until the reinstatement of the license in good standing. Failure to maintain licensure/certification will result in deductions from the LME's invoice.

**F. Staffing Requirements for Adverse Action Determinations**

Service authorization reviews that result in an adverse action (denials, reductions, terminations, or suspension) based on the absence of medical necessity, must be made by appropriate clinical staff:

- If the service authorization request is for mental health services for a recipient aged 21 or older, the determination must be made by a psychiatrist holding an unencumbered N.C. Medical License who board-certified in psychiatry.
- If the service authorization request is for mental health services for a recipient under the age of 21, the determination must be made by a psychiatrist holding an unencumbered N.C. Medical License who is board certified or board eligible in child psychiatry.
- If the service authorization request is for substance abuse treatment services for a recipient aged 21 and older, the determination must be made by a psychiatrist holding an unencumbered N.C. Medical License and who is board certified in psychiatry or physician holding an unencumbered N.C. Medical License and who is board certified or board eligible in ASAM.
- If the service authorization request is for substance abuse treatment services for a recipient under the age of 21, the determination must be made by a psychiatrist holding an unencumbered N.C. Medical License who is board certified or board eligible in child psychiatry or physician holding an unencumbered N.C. Medical License and who is board certified or board eligible in ASAM.
- For mental health services reviewed under EPSDT criteria for a recipient under the age of twenty-one (21) that result in an adverse action (denials, reductions, terminations, or suspension) based upon the absence of medical necessity must be made by a child psychiatrist.
- For services related to developmental disabilities that result in an adverse action (denials, reductions, terminations, or suspension) based upon the absence of medical necessity must be made by a physician or licensed psychologist.

**G. Subcontracts**

The LME must not subcontract with any entity to provide the utilization management functions outlined in the document.

**V. PROVIDER ASSISTANCE**

In addition to clinical staff, the LME must provide a staff representative who will handle provider complaints and problems, and must provide sufficient telephone lines and staff to ensure that providers have access to assistance.

**A. Call Center**

The LME must provide sufficient telephone lines and staff to ensure that calls are answered within five (5) rings.

**B. Provider Representative**

The staff provider representative must be readily available during working hours (Monday through Friday, 8:00 a.m. to 6:00 p.m.) to receive calls and take actions to solve problems.

- Calls must be returned within two (2) business hours of receipt.
- The staff provider representative must maintain a call log that, at a minimum, includes the following items:
  - ◆ Name of provider agency
  - ◆ Name and contact information of caller
  - ◆ Date and time of call
  - ◆ Disposition
  - ◆ Nature of the problem/complaint
  - ◆ Resolution of the problem/complaint
  - ◆ Date and time of the resolution
  - ◆ Date and time of LME response
  - ◆ Was inquirer satisfied with response

**C. Provider Inquiry/Complaint Resolution Process**

The provider representative must respond to calls from service providers with an inquiry or a complaint. If the provider representative is available when the call is received, the nature of the complaint/inquiry will dictate if the provider representative can resolve the issue.

If the provider representative is not available, the service provider can leave a voice mail message, which will be returned by the provider representative within two (2) business hours.

If the provider representative can resolve the inquiry/complaint, action is taken to resolve the issue, and the provider is notified of resolution.

- If the resolution is favorable, the inquiry/complaint is closed.
- If the decision is not favorable, the grievance/appeal process is given to the provider.

If the provider representative is not qualified to respond to the inquiry/complaint, the provider representative routes the inquiry/complaint to the appropriate staff.

- For clinical inquiries/complaints, the call is routed to the LME clinical supervisor.
- For non-clinical inquiries/complaints, the call is routed to the appropriate area.

The provider representative continues to monitor the status of the referred inquiry/complaint and must notify the service provider by the 25<sup>th</sup> day.

- If the resolution is favorable, the inquiry/complaint is closed.
- If the decision is not favorable, the grievance/appeal process is given to the service provider.

If an inquiry/complaint is not resolved by the 25<sup>th</sup> day, the provider representative calls the service provider with the status of the inquiry/complaint, and the expected resolution date.

- If the expected resolution date is not met, the provider representative calls the provider with the status of the inquiry/complaint, and the expected resolution date.
- If the inquiry/complaint is met by the expected date, the service provider is notified of the resolution.
  - ◆ If the resolution is favorable, the inquiry/complaint is closed.
  - ◆ If the decision is not favorable, the grievance/appeal process is given to the service provider.

#### D. Provider Assistance Reports

The LME must

- Capture data on average speed of answer, average hold time, call volume, and call abandonment rates. This data must be furnished electronically to DMA on a weekly basis through the Weekly Summary Inbound File (see **Section XX.B.3.**).
- Capture data on provider complaints/issues and provide a trend analysis report to DMA on a quarterly basis related on issues and proposed solutions related to provider calls.

## VI. UTILIZATION MANAGEMENT

The LME is responsible for utilization management of Medicaid-funded behavioral health, developmental disability, and substance abuse treatment services by conducting the following activities:

- Authorization and re-authorization of **outpatient** behavioral health services provided by direct-enrolled mental health practitioners.
- Authorization, re-authorization, and concurrent reviews for the following **enhanced** (Community Intervention Services) behavioral health services:
  - ◆ Ambulatory Detoxification
  - ◆ Assertive Community Treatment Team
  - ◆ Child and Adolescent Day Treatment
  - ◆ Community Support Services
  - ◆ Diagnostic Assessment
  - ◆ Intensive In Home
  - ◆ Medically Supervised or ADATC Detoxification/Crisis Stabilization
  - ◆ Mobile Crisis Management
  - ◆ Multisystemic Therapy
  - ◆ Non Hospital Detoxification
  - ◆ Opioid Treatment
  - ◆ Partial Hospital
  - ◆ Professional Treatment Services in Facility Based Crisis Programs
  - ◆ Psychosocial Rehabilitation
  - ◆ Substance Abuse comprehensive Outpatient Treatment Program
  - ◆ Substance Abuse Intensive Outpatient Program
  - ◆ Substance Abuse Medically Monitored Community Residential Treatment
  - ◆ Substance Abuse Non Medical Community Residential Treatment
- Admissions and concurrent reviews for **inpatient** mental health and substance abuse treatment services, including **psychiatric residential treatment facility** services.

- Admissions and concurrent reviews for **residential child care treatment (Levels I through IV) facility** services.
- Authorization and concurrent reviews of services for recipients under the age of 17 provided under **Criterion 5**.
- Authorization, re-authorization, and concurrent reviews of **therapeutic foster care** services.
- Authorization reviews for **CAP/MR-DD** services or **targeted case management** services including continued needs reviews and discrete change reviews.
- Authorization, re-authorization, and concurrent reviews of **out-of-state** services for recipients under the age of 21.

Additionally, the LME is responsible for utilization management of Medicaid-funded behavioral health, developmental disability, and substance abuse treatment services for the following types of reviews:

- Early Periodic Screening, Diagnostic, and Treatment (EPSDT) reviews
- Retrospective reviews
- Special team reviews
- Quality assurance reviews

## VII. UTILIZATION REVIEW COMPONENTS

### A. Medical Necessity

Medical necessity is defined as those procedures, products, and services that are provided to Medicaid recipients that are necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health or substance abuse condition when the procedure, product, or services are:

- Consistent with N.C. DHHS-defined standards, Medicaid clinical coverage criteria, and national or evidence-based standards verified by independent clinical experts at the time the procedures, products, or services are provided.
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.
- Able to be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide (this should be linked with network development in the catchment area).
- Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
- Not for experimental, investigational, unproven or solely cosmetic purposes.
- Furnished by or under the supervision of a practitioner licensed (as relevant) under state law in the specialty for which they are providing service and in accordance with federal and state laws and regulations, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid clinical coverage policies, and other applicable federal and state directives.
- Sufficient in amount, duration and scope to reasonably achieve their purpose.
- Reasonably related to the diagnosis for which they are prescribed regarding type, intensity, duration of service and setting of treatment.

**B. Medical Necessity Criteria**

The LME must follow the medical necessity criteria delineated in the service definitions for a particular service and appropriate Medicaid clinical coverage policies to determine the appropriateness of the following services for eligible populations. Refer to the links listed below for access to the services definitions and clinical coverage policies.

- **Outpatient Behavioral Health Services**  
Medical necessity criteria are defined in Clinical Coverage Policy #8C (<http://www.ncdhhs.gov/dma/mp/mpindex.htm>).
- **Enhanced (Community Intervention Services) Behavioral Health Services**  
Medical necessity criteria is defined in Clinical Coverage Policy #8A (<http://www.ncdhhs.gov/dma/mp/mpindex.htm>).
- **Inpatient Behavioral Health Services**  
Medical necessity criteria are defined in Clinical Coverage Policy #8B (<http://www.ncdhhs.gov/dma/mp/mpindex.htm>).
- **Residential Child Care Treatment (Levels I through IV) Facility Services**  
Medical necessity criteria are defined in Clinical Coverage Policy #8D-2 (<http://www.ncdhhs.gov/dma/mp/mpindex.htm>).
- **Psychiatric Residential Treatment Facility Services**  
Medical necessity criteria are defined in Clinical Coverage Policy #8D-1 (<http://www.ncdhhs.gov/dma/mp/mpindex.htm>).
- **Criterion 5 Services**  
Medical necessity criteria are defined in Clinical Coverage Policy #8B (<http://www.ncdhhs.gov/dma/mp/mpindex.htm>).
- **CAP/MR-DD**  
Medical necessity criteria are defined in the CAP/MR-DD waiver (<http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm>).
- **Targeted Case Management**  
Medical necessity criteria are defined in the July 2005 Special Bulletin, *Targeted Case Management for Mentally Retarded/Developmentally Disabled (MR/DD) Individuals* (<http://www.ncdhhs.gov/dma/bulletinspecial.htm>).
- **Therapeutic Foster Care**  
Medical necessity criteria are defined in Clinical Coverage Policy #8D-2 (<http://www.ncdhhs.gov/dma/mp/mpindex.htm>).

- **Out-of-state Services**

Medical necessity criteria are related to the specific service that is being requested.

**C. Early Periodic Screening, Diagnosis and Treatment Requirements**

Service authorization requests must be reviewed under Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements if adverse action is to be taken on a request because the request exceeds policy limitations. If all EPSDT criteria are met, the service request should be approved even if policy limitations are exceeded. For further information see the guidelines published in the EPSDT Policy Instruction Update on DMA's website at <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>.

**D. Residential Child Care Treatment (Levels I through IV) Facility Provider Enrollment Data**

Authorization of Residential Child Care Treatment (Levels I through IV) facility services requires the LME to determine not only medical necessity but also to determine the appropriate State-created code to correspond with both level of care and provider enrollment information.

DMA will provide the LME with a spreadsheet (see **Attachment B**) on a bi-weekly basis documenting the following information for the enrollment of residential treatment facility providers:

- bed capacity
- approved treatment level
- licensure date
- endorsement
- effective date of enrollment

The spreadsheet also includes changes to an enrolled provider's bed capacity and approved levels of care.

The LME must use this spreadsheet to confirm that the service provider is licensed and endorsed to provide the level of service being requested and to determine the appropriate State-created procedure code to indicate on the authorization request entered into the automated system and exported to the Fiscal Agent's system.

The service request must include a detailed description of the level of care that is being requested. The LME must determine the correct State-created code to assign to the authorization based on the HCPCS procedure code that identifies the level of care indicated on the service authorization request submitted by the service provider.

Following is a table listing the HCPCS procedure codes for residential child care treatment (Levels I through IV) and therapeutic foster care and the corresponding State-created codes.

<b>HCPCS Procedure Code</b>	<b>Service Description</b>	<b>State-created Code</b>
S5145 *	Therapeutic Foster Care	Y2362
H0046 *	Level I Group Home	Y2347
H2020	Level II Group Home	Y2363
H0019	Level III Group Home – 4 beds or fewer	Y2348
H0019	Level III Group Home – 5 beds or more	Y2349
H0019	Level IV Group Home – 4 beds or fewer	Y2360
H0019	Level IV Group Home – 5 beds or more	Y2361

\* These two RCC services are always billed using the LME's Medicaid provider number.

#### **E. Service Authorization Request Documentation**

The service provider initiates the authorization/re-authorization process by completing and submitting the Service Request Form (see **Attachment C**). The information that is provided on the form includes, but is not limited to,

- the recipient's Medicaid identification number
- the recipient's diagnosis (DSM-IV, Axis I-V)
- date of initial assessment and/or subsequent assessments prior to referral
- history of previous treatment, including treatment response and dates of most recent hospitalization, if applicable
- reason/need for initial or continued treatment
- extent of danger to self or others/risk assessment
- substance abuse history, including types and amounts of substances abused, and the dates of initial use and most recent use, withdrawal symptoms, and vital signs from assessment
- medical problems, including medical history and medical problems that may exacerbate psychiatric symptoms or substance abuse problems
- medications that are currently prescribed, including the dosages, and medications to which the recipient has experienced adverse reactions
- the name of the recipient's primary care physician, (attending/referring physician) and Medicaid provider number
- demographic information
- information on custody/guardianship

For Criterion 5, the request must be submitted using the Criterion 5 Service Needs/Discharge Planning Status Form (see **Attachment D**).

The following documents must be submitted with the form:

- If the service provider is requesting authorization for **enhanced** (Community Intervention Services) behavioral health services, a copy of the recipient's person centered plan is required with updated goals and signatures within the past 30 days.  
**Note:** Depending on the applicable service definition, the service provider may submit either an introductory person centered plan or a complete person centered plan with the authorization request. If an introductory person centered plan is submitted, the service provider must submit the complete person centered plan prior to the end of the authorization period.
- If the service provider is requesting authorization for **outpatient** behavioral health services, the following documentation must also be included with the authorization request:
  - ◆ a written service order signed by a physician, Ph.D. psychologist, physicians assistant, or nurse practitioner
  - ◆ a copy of the recipient's treatment plan
- If the service provider is requesting authorization for admission of a recipient for **inpatient services**, a copy of the complete person centered plan is required.  
**Note:** If the admission is to a **psychiatric unit within a general hospital**, a copy of the complete person centered plan is not required; only the Service Request Form is required.
- If the service provider is requesting authorization for admission of a recipient under the age of twenty-one (21) to a free-standing psychiatric facility (**hospital/psychiatric residential treatment facility**), the following documentation must also be included with the authorization request:
  - ◆ certification of need (CON)
    - Certification of Need: Medicaid Inpatient Psychiatric Services Under Age 21
    - OR
    - Certification of Need: Psychiatric Residential Treatment Facility Service Under Age 21Available on line at <http://www.ncdhhs.gov/dma/formsprov.html#bh> (see also **Attachment E**).
  - ◆ a copy of the complete person centered plan
- If the service provider is requesting authorization for **CAP/MR-DD** services, a complete packet of documentation, including, but not limited to, the following documents are also required:
  - ◆ contact information for the recipient's case manager
  - ◆ a copy of the complete person centered plan, including crisis plan

- ◆ a current MR2
  - for an initial request, the MR2 must be signed by the physician
  - for a re-authorization request, the MR2 must be signed by the LME and the qualified professional
- Note:** The MR2 must be signed and dated prior to the date of the person centered plan.
- ◆ the full NC SNAP document
- ◆ psychological evaluation with the initial person centered plan, which includes adaptive functioning
- ◆ supporting assessments
- ◆ cost summary
- If the service provider is requesting authorization for **targeted case management** services, a complete packet of documentation, including, but not limited to, the following documents are also required:
  - ◆ a copy of the complete person centered plan

**Note:** The service provider for the MR-DD population is a targeted case manager serving that individual)

#### **F. Receipt of Service Authorization Requests**

The LME must be able to accept secure transmissions from the service provider via surface mail, telephone, and secure electronic submissions to include e-mail, web-based, and fax.

#### **G. Timeframes for Response to Initial Requests for Service Authorization**

The LME must use their best judgment based on level of need to determine the timeframe for response. Requests can be approved, denied, reduced, terminated, suspended, or pended for additional information.

Requests are pended when there is inadequate clinical information provided to approve, deny, reduce, terminate, or suspend the request. The LME will inform the service provider in writing using a letter format approved by DMA that additional information is required within fifteen (15) business days from the date of the notice. If the service provider does not submit the requested information or does not contact the LME prior to the due date to request a time extension (no more that an additional fifteen (15) business days can be granted), the request is denied in writing on day 16. The notice denial is sent to the service provider, recipient and/or legal representative.

A written notification of the decision, including the parameters of the authorizations or details of the adverse action (denials, reductions, terminations, or suspension) must be provided to the recipient and/or legal representative and the service provider within one (1) day of the decision.

##### **1. Emergent/Urgent Residential or Inpatient Admissions**

Emergent is defined as a life threatening or non-life threatening emergency requiring a face-to-face treatment/assessment within two (2) hours of the initiation of the request.

Service authorization requests that are identified as emergent require a response within four (4) business hours from receipt of a complete service authorization request.

It is recommended that the LME have a dedicated fax line for these requests to quickly identify them as Emergent/Urgent Residential or Inpatient Admissions.

**2. Routine**

Recipients with routine service needs require a response within five (5) business days from receipt of a complete service authorization request.

**3. CAP/MR-DD and Targeted Case Management**

Service requests for CAP/MR-DD waiver services or targeted case management services require a response within ten (10) business days of receipt of the complete service authorization request.

**4. Criterion 5**

Service requests for Criterion 5 require a response within five (5) business days.

**5. Out-of-state Services**

Service requests for out-of-state services require a response within five (5) business days.

**6. EPSDT**

Services reviewed under EPSDT guidelines require a response within fifteen (15) calendar days.

**H. Timeframes for Response to Requests for Service Re-authorization**

The LME must respond to service requests for re-authorizations within five (5) business days of the receipt of a complete service authorization request except as follows:

- Requests for the re-authorization of hospital inpatient services require a response within one (1) business day of the receipt of a complete service authorization request.

**I. Timeframes for Response to Requests for Retrospective Reviews**

The LME must respond to a request for retrospective review within sixty (60) days from the receipt of a complete request.

**J. Recipient Eligibility**

**1. Eligibility File**

The Division of Information Resource Management (DIRM) will supply the LME with recipient eligibility information, which is required for the processing of authorizations and claims. This information can be used by the LME to obtain the recipient's address to use on notices, to verify the date of birth, and to determine the county of eligibility. This information will be sent via FTP daily.

**2. Cross Referenced Medicaid Identification Numbers**

There are instances when a recipient may have more than one Medicaid identification (MID) number assigned to them. In most instances when this occurs, the numbers are cross referenced and both numbers will be sent to the LME on the eligibility file.

The cross-reference to the original MID number ensures that where the eligibility data indicates more than one MID number for the same recipient, the LME can identify the current MID number and authorize services using the correct MID number.

In circumstances where the recipient is a child whose identity must be protected because of an adoption, the recipient's original MID number is terminated and a new MID number is assigned. The new MID number is not cross referenced to the original MID number.

In this situation, or in any situation where the same recipient has two numbers that are not cross referenced, the LME must contact the DMA Eligibility Information System Unit and the DMA Medicaid Eligibility Unit by e-mail to verify eligibility and confirm the correct MID number.

The details of the request must be sent as a password-protected (the password is Medicaid) attachment by e-mail to [jonnette.earnhardt@ncmail.net](mailto:jonnette.earnhardt@ncmail.net) and [Carolyn.mcclanahan@ncmail.net](mailto:Carolyn.mcclanahan@ncmail.net).

If it is an error and the numbers should be cross referenced, the correction will be made by the local county department of social services. Once corrected, the MID number will be sent to the LME on the next eligibility file as cross referenced.

If it is correct and the MID numbers should **not** be cross referenced, the LME will be notified by DMA. The LME must manually move the authorizations to the new MID number based on date of service and effective date of the new MID number.

**K. Provider Eligibility**

DMA's Fiscal Agent will supply the LME with provider enrollment information, which is required for the processing of authorizations. This information will be used by the LME to verify the provider's address for use on service authorization request notifications; to verify the service provider's Medicaid provider number; to ensure that the service provider is active and in good standing with Medicaid; and to verify that the service provider is eligible to provide the treatment/service that is being requested.

The provider eligibility database file will be sent to the LME on a daily basis via FTP.

## VIII. TYPES OF UTILIZATION REVIEWS

All reviews must be performed by the LME clinical staff with expertise relevant to the nature of the recipient's disability for whom services are intended.

The clinical care manager may make recommendations to the treating clinician/service provider to reduce or modify services when a service authorization request does not meet medical necessity criteria. The clinical care manager may not threaten or use coercion to get the provider to accept the recommendation. If the treating clinician/service provider does not agree to the recommendation, the clinical care manager cannot deny the service request. Denials of service or recommendations to reduce or modify services must be forwarded to the appropriate physician or licensed psychologist for denial determinations.

Service authorization requests for recipients under the age of twenty-one (21) that exceed unit or visit limitations or age exclusions as delineated in the service definitions or clinical coverage policies for the service must be reviewed under EPSDT guidelines.

The LME may approve the request if all the EPSDT criteria are met even though clinical coverage policy criteria were not met. The LME must deny, reduce (change), or terminate the request if all the EPSDT criteria are not met.

The LME may refer a service authorization request to DMA if it is determined that a Medicaid-covered service other than the behavioral health, developmental disability, and substance abuse treatment services that are within the utilization management functions provided by the LME would more appropriately serve the recipient.

### A. Initial Reviews

Initial reviews are completed for requests of service where, typically, the recipient is new to the service being requested or the request is submitted after a break in service from the last date of authorized service.

**Note:** If a request for re-authorization of services for a recipient is submitted by a new service provider, it is considered to be an initial request.

### B. Concurrent Reviews for Re-authorization of Service

Concurrent reviews are required when:

- The service provider recommends and requests authorization for care beyond the dates of service that were initially authorized.
- The service provider requests a revision to the level of care that was initially authorized.

The purpose of a concurrent review is to determine if the authorized service continues to be appropriate at the current level and, if not, what alternative services are to be considered. The LME must assure that the least restrictive and most cost-effective service option that appropriately addresses the need, for which the original service was authorized, is being utilized.

Requests for re-authorization must be submitted to the LME prior to the end of the current authorization period. If a request for re-authorization is submitted AFTER the end of the previous authorization period, it will be handled as an initial request.

**Note:** If a request for re-authorization of services for a recipient is submitted by a new service provider, it is considered to be an initial request.

**C. EPSDT Reviews**

EPSDT reviews are defined as reviews for service authorization requests for recipients under the age of twenty-one (21) when the service(s) requested exceed unit or visit limitations or age exclusions as delineated in the service definitions or clinical coverage policies for the service. As documented in the EPSDT requirements (42 U.S.C. 1396d(r) {1905(r)} of the Social Security Act), requests for services beyond the established limitations or exclusions must be considered if they are medically necessary to correct or ameliorate the condition.

Services reviewed under EPSDT guidelines require a response within fifteen (15) calendar days.

**D. Requests for Non-Covered Services**

Requests for mental health or substance abuse treatment services for recipients under the age of twenty-one (21) that are not covered by Medicaid must also be reviewed and recommendations must be sent to DMA's Assistant Director for Clinical Policy and Programs Section for a final decision. The LME must notify the service provider in writing that the request was referred to DMA for disposition.

**E. Retrospective Reviews**

**1. Medicaid Eligibility**

Retrospective reviews may be performed if the recipient did not have Medicaid at the time the service was provided but obtains Medicaid eligibility with an effective date that encompasses the dates that the service was provided.

The service provider must submit all records to the LME within the following timeframes after verifying Medicaid eligibility.

The LME must make a decision within 60 days of the receipt of a complete request.

The records must be submitted with the Service Request Form and the authorization documentation specific to the service (see **Section VII.E.**) being requested. Any authorization information from a different vendor or LME that may have been applicable during the period of services to be reviewed should be included with the request.

Where Medicaid eligibility was approved after the service was provided, authorization for inpatient, outpatient or enhanced services typically should not exceed six (6) months from the date of eligibility (depending on the authorization increments delineated in the service definition or clinical coverage policy for the service). However, there may be circumstances that require additional time for determining eligibility.

Additional retrospective reviews for enhanced services may be requested by DMA due to provider or client specific situations.

**2. Provider Transfers**

Exceptional circumstances may occur where DMA requests concurrent authorization of services to transfer a client to a different service provider without individual review of client information.

When this request is made, DMA will coordinate with DMH and the responsible LME for submission of client transfers to a different provider.

A spreadsheet of individual client changes will be provided and transfer of authorization based upon historical review of medical necessity will occur. Following this initial transfer, concurrent review standards will apply.

**F. Special Team Reviews**

On rare occasions, DMA may request the LME must perform an on-site special team evaluation. These monitoring reviews will be conducted for various reasons. A review may be requested to evaluate the needs of an individual or to monitor a program within a facility.

At a minimum, the team must be comprised of a licensed psychologist and a licensed or certified practitioner with expertise relevant to the disability of the individual for whom services are being reviewed. Additional professional team members may be used as needed to effectively represent the multiple needs of an individual, or the multiple services provided by a program.

Written results of the visit must be communicated to DMA within ten (10) working days of the completion of the review.

**G. Quality Assurance****1. Quality Assurance Reviews**

The LME must perform quality assurance reviews for Medicaid reimbursable services. The sample size will be selected based on the size needed for a valid review of the service. These services must be individually reviewed with the sample size selected by the nature of the service. Medical records must be requested for each service reviewed and criteria applied as agreed upon by the LME and DMA.

Each month, DMA will pull a statewide sample of forty (40) records for CAP/MR-DD waiver services. The LME must conduct record reviews for the identified recipients that are assigned to the LME's catchment area and send the reviews to DMA.

The LME must forward all relevant documentation to DMA concerning any identified problems. DMA's Program Integrity Section will then be responsible for any subsequent review or disposition of the problem.

Appeals and grievance procedures apply if these reviews reveal the absence of medical necessity. Any denial of medical necessity must be made by the LME's physician consultant or licensed clinical psychologist.

Quality assurance monitoring must be performed by the LME for all services and for outpatient services billed with CPT procedure codes and HCPCS procedure codes. Selected quality assurance reviews may be requested by DMA for additional authorized enhanced and CAP/MR-DD services within the scope of the contract.

## 2. **Quality of Care Complaints**

If at any time a clinical care manager becomes aware of circumstances that may be a quality of care issue (adverse incident), the LME must notify DMA of the complaint using the Notification of Quality of Care memo template (see **Attachment F**).

The following information must be indicated on the memo:

- Name of recipient
- Recipient's MID number
- The dates of service the recipient was under the clinical home provider's care
- The name and address of the service provider
- The service provider's Medicaid provider number
- The level of care provided by the service provider
- The dates of service for the service provider
- The name of the individual making the complaint
- A summary of the complaint

The completed Notification of Quality of Care memo is sent to the Chief of DMA's Behavioral Health Services Unit for disposition.

A summary of quality of care complaints is provided by the LME to DMA on a quarterly basis (see **Section XXI.B.1.**).

## **IX. Authorization Process**

The LME cannot authorize services for dates of service prior to the receipt of the authorization request unless the request meets the criteria for a retrospective reviews (see **Section VIII.E.**).

The LME will use the established authorization period for initial authorizations and re-authorizations indicated in **Attachment G**.

The LME's UM medical director must ensure that authorization reviews are conducted by appropriate staff with experience relevant to the disability of the individual for whom services are being reviewed (see **Section IV.**).

At any point during the authorization process the service provider may request to speak to the physician rendering an adverse decision.

Service authorization reviews should be completed using the Clinical Review Form (see **Attachment H.**) All approvals or adverse decisions must be documented on the form.

### **A. Outpatient Behavioral Health Services**

#### **1. Initial Authorization Reviews**

The authorization process is initiated when the service provider submits a completed Service Request Form to the LME. The LME must respond within the timeframes specified in **Section VII.G**. The LME reviews the form to verify that the request includes the required information and documentation listed in **Section VII.E**.

If the clinical care manager determines that the request meets any of the criteria for denial due to administrative reasons (see **Section X.D.**)

- The clinical care manager does NOT review the request for medical necessity.
- The clinical care manager documents the denial (see **Section X.D.**).
- A written notification of the denial must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

The LME reviews the Service Request Form to determine if it was received prior to the required trigger points.

- For recipients ages 21 and older, the trigger point is 8 unmanaged visits.
- For recipients under 21 years of age, the trigger point is 26 unmanaged visits.

**Note:** Payment will be denied by the Fiscal Agent for any services that were provided between the trigger point and the date the Service Request Form was received by the LME.

If the request meets trigger point requirements, the clinical care manager reviews the clinical information indicated on the Service Request Form and the treatment/service plan submitted with the form to determine if medical necessity is met for any further outpatient visits.

If the clinical care manager determines that medical necessity is met:

- The clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is met, but the request exceeds the maximum time allowed for the service, the age of the recipient for whom the service is intended determines the disposition of the request.

- If the service authorization request is for a recipient aged 21 or older, the clinical care manager authorizes treatment/service for the maximum time allowable and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

- If the service authorization request is for a recipient under the age of 21, the LME UM medical director reviews the request using EPSDT criteria.
  - ♦ If the service authorization request meets the EPSDT criteria, the clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is not met, the LME contacts the treating clinician/service provider regarding treatment/service that meets medical necessity (see **Section X.C.**).

- If an agreement cannot be reached regarding treatment/service, the case is forwarded to the LME UM medical director for peer review.
- If the service authorization request is for a recipient under the age of 21, the LME UM medical director reviews the request using EPSDT criteria.
- The LME UM medical director may contact the treating clinician/service provider to consult on the treatment/service.

If the review results in a determination that medical necessity is met, then the care is authorized.

- The clinical care manager authorizes treatment and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the review results in a determination that medical necessity may be met by reducing or authorizing alternative treatment/service,

- The clinical care manager contacts the treating clinician/service provider to discuss revising the treatment/service plan.
- If the treating clinician/service provider agrees with the revisions, the clinical care manager documents the discussion in the record.
- The service provider must obtain approval from the recipient for the revised treatment/service plan.
- The authorization request is pended (see **Section X.B.**) until the service provider notifies the clinical care manager of the recipient's approval. This must be received within fifteen (15) business days.

**Note:** If the recipient's approval is not obtained the request must be denied, reduced, terminated, or suspended on day 16.

- Upon receipt of the recipient's approval, the LME documents the record.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If it is determined that medical necessity is not met or an agreement to revise the treatment/service plan to meet medical necessity cannot be reached, the LME must deny, reduce, or terminate the service (see **Section X.E.**).

- The LME must notify the treating clinician/service provider by telephone on the day the adverse action is completed.
- A detailed written notification of the action (see **Section XI.**) must also be sent to the service provider and the recipient and/or his/her legal representative the treating clinician/service provider within one (1) business day.
- The LME must post the adverse action notice to the DMH/OAH secure website.

## 2. **Concurrent Reviews for Re-authorization Requests**

The re-authorization process is initiated when the service provider submits a completed Service Request Form and updated clinical information to the LME. The LME must respond within the timeframes specified in **Section VII.H.**

If the clinical care manager determines that the request meets any of the criteria for denial due to administrative reasons (see **Section X.D.**)

- The clinical care manager does NOT review the request for medical necessity.
- The clinical care manager documents the denial (see **Section X.D.**).
- A written notification of the denial must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is met:

- The clinical care manager authorizes treatment and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is met, but the request exceeds the maximum time allowed for the service, the age of the recipient for whom the service is intended determines the disposition of the request.

- If the service authorization request is for a recipient aged 21 or older, the clinical care manager authorizes treatment/service for the maximum time allowable and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

- If the service authorization request is for a recipient under the age of 21, the LME UM medical director reviews the request using EPSDT criteria.
  - ♦ If the service authorization request meets the EPSDT criteria, the clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is not met, the LME contacts the treating clinician/service provider regarding treatment/service that meets medical necessity (see **Section X.C.**).

- If an agreement cannot be reached regarding treatment/service, the case is forwarded to the LME UM medical director for peer review.
- If the service authorization request is for a recipient under the age of 21, the LME UM medical director reviews the request using EPSDT criteria.
- The LME UM medical director may contact the treating clinician/service provider to consult on the treatment/service plan.

If the review results in a determination that medical necessity is met, then the care is authorized.

- The clinical care manager authorizes treatment and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the review results in a determination that medical necessity may be met by reducing or authorizing alternative treatment/service,

- The clinical care manager contacts the treating clinician/service provider to discuss revising the treatment/service plan.
- If the treating clinician/service provider agrees with the revisions, the clinical care manager documents the discussion in the record.
- The service provider must obtain approval from the recipient for the revised treatment/service plan.
- The authorization request is pending (see **Section X.B.**) until the service provider notifies the clinical care manager of the recipient's approval. This must be received within fifteen (15) business days.

**Note:** If the recipient's approval is not obtained the request must be denied, reduced, terminated, or suspended on day 16.

- Upon receipt of the recipient's approval, the LME documents the record.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If it is determined that medical necessity is not met or an agreement to revise the treatment/service plan to meet medical necessity cannot be reached, the LME must deny, reduce, or terminate the service (see **Section X.E.**).

- The LME must notify the treating clinician/service provider by telephone on the day the adverse action is completed.
- A detailed written notification of the action (see **Section XI.**) must also be sent to the service provider and the recipient and/or his/her legal representative the treating clinician/service provider within one (1) business day.
- The LME must post the adverse action notice to the DMH/OAH secure website.
- Where applicable, the LME must issue maintenance of services authorization (see **Section XIII.**).

**B. Enhanced (Community Intervention Services) Behavioral Health Services**

**1. Initial Authorization Reviews**

The authorization process is initiated when the service provider submits a completed Service Request Form to the LME. The LME must respond within the timeframes specified in **Section VII.G.** The LME reviews the form to verify that the request includes the required information and documentation listed in **Section VII.E.**

If the clinical care manager determines that the request meets any of the criteria for denial due to administrative reasons (see **Section X.D.**)

- The clinical care manager does NOT review the request for medical necessity.
- The clinical care manager documents the denial (see **Section X.D.**).
- A written notification of the denial must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is met

- The clinical care manager authorizes treatment and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is met, but the request exceeds the maximum time allowed for the service, the age of the recipient for whom the service is intended determines the disposition of the request.

- If the service authorization request is for a recipient aged 21 or older, the clinical care manager authorizes treatment/service for the maximum time allowable and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.
- If the service authorization request is for a recipient under the age of 21, the LME UM medical director reviews the request using EPSDT criteria.
  - ♦ If the service authorization request meets the EPSDT criteria, the clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is not met, the LME contacts the treating clinician/service provider regarding a person centered plan that meets medical necessity (see **Section X.C.**).

- If an agreement cannot be reached regarding treatment, the case is forwarded to the LME UM medical director for peer review.
- If the service authorization request is for a recipient under the age of 21, the LME UM medical director reviews the request using EPSDT criteria.
- The LME UM medical director may contact the treating clinician/service provider to consult on the person centered plan.

If the review results in a determination that medical necessity is met, then the care is authorized.

- The clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the review results in a determination that medical necessity may be met by reducing or authorizing alternative treatment/service,

- The clinical care manager contacts the treating clinician/service provider to discuss revising the treatment/service plan.
- If the treating clinician/service provider agrees with the revisions, the clinical care manager documents the discussion in the record.
- The service provider must obtain approval from the recipient for the revised treatment/service plan.
- The authorization request is pended (see **Section X.B.**) until the service provider notifies the clinical care manager of the recipient's approval. This must be received within fifteen (15) business days.

**Note:** If the recipient's approval is not obtained the request must be denied, reduced, terminated, or suspended on day 16.

- Upon receipt of the recipient's approval, the LME documents the record.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If it is determined that medical necessity is not met or an agreement to revise the treatment/service plan to meet medical necessity cannot be reached, the LME must deny, reduce, or terminate the service (see **Section X.E.**).

- The LME must notify the treating clinician/service provider by telephone on the day the adverse action is completed.
- A detailed written notification of the action (see **Section XI.**) must also be sent to the service provider and the recipient and/or his/her legal representative the treating clinician/service provider within one (1) business day.
- The LME must post the adverse action notice to the DMH/OAH secure website.

## **2. Concurrent Reviews for Re-authorization Requests**

The re-authorization process is initiated when the service provider submits a completed Service Request Form and updated clinical information to the LME. The LME must respond within the timeframes specified in **Section VII.H.**

If the clinical care manager determines that the request meets any of the criteria for denial due to administrative reasons (see **Section X.D.**)

- The clinical care manager does NOT review the request for medical necessity.
- The clinical care manager documents the denial (see **Section X.D.**).
- A written notification of the denial must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is met:

- The clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is met, but the request exceeds the maximum time allowed for the service, the age of the recipient for whom the service is intended determines the disposition of the request.

- If the service authorization request is for a recipient aged 21 or older, the clinical care manager authorizes treatment/service for the maximum time allowable and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.
- If the service authorization request is for a recipient under the age of 21, the LME UM medical director reviews the request using EPSDT criteria.
  - ♦ If the service authorization request meets the EPSDT criteria, the clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is not met, the LME contacts the treating clinician/service provider regarding a person centered plan that meets medical necessity (see **Section X.C.**).

- If an agreement cannot be reached regarding treatment/service, the case is forwarded to the LME UM medical director for peer review.
- If the service authorization request is for a recipient under the age of 21, the LME UM medical director reviews the request using EPSDT criteria.
- The LME UM medical director may contact the treating clinician/service provider to consult on the person centered plan.

If the review results in a determination that medical necessity is met, then the care is authorized.

- The clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the review results in a determination that medical necessity may be met by reducing or authorizing alternative treatment services,

- The clinical care manager contacts the treating clinician/service provider to discuss revising the treatment/service plan.
- If the treating clinician/service provider agrees with the revisions, the clinical care manager documents the discussion in the record.
- The service provider must obtain approval from the recipient for the revised treatment/service plan.
- The authorization request is pending (see **Section X.B.**) until the service provider notifies the clinical care manager of the recipient's approval. This must be received within fifteen (15) business days.

**Note:** If the recipient's approval is not obtained the request must be denied, reduced, terminated, or suspended on day 16.

- Upon receipt of the recipient's approval, the LME documents the record.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If it is determined that medical necessity is not met or an agreement to revise the treatment/service plan to meet medical necessity cannot be reached, the LME must deny, reduce, or terminate the service (see **Section X.E.**).

- The LME must notify the treating clinician/service provider by telephone on the day the adverse action is completed.
- A detailed written notification of the action (see **Section XI.**) must also be sent to the service provider and the recipient and/or his/her legal representative the treating clinician/service provider within one (1) business day.
- The LME must post the adverse action notice to the DMH/OAH secure website.
- Where applicable, the LME must issue maintenance of services authorization (see **Section XIII.**).

**C. Inpatient Behavioral Health Services, Including Psychiatric Residential Treatment Facility Services**

**1. Initial Authorization Reviews**

The service facility contacts the LME for authorization prior to admission. Contact may be initiated by the service facility by telephone; however, the service facility must follow up the verbal contact by submitting a Service Request Form. The LME must respond within the timeframes specified in **Section VII.G.** The LME reviews the form to verify that the request includes the required information and documentation listed in **Section VII.E.**

If the service facility is requesting authorization for admission of a recipient under the age of 21 to a free-standing psychiatric facility (**hospital/psychiatric residential treatment facility**), the LME requests a CON (<http://www.ncdhhs.gov/dma/formsprov.html#bh>) from the service provider.

If the clinical care manager determines that the request meets any of the criteria for denial due to administrative reasons (see **Section X.D.**)

- The clinical care manager does NOT review the request for medical necessity.
- The clinical care manager documents the denial (see **Section X.D.**).
- A written notification of the denial must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

The clinical care manager reviews the clinical information and determines if medical necessity is met based on approved Medicaid criteria and policy.

If the clinical care manager determines that medical necessity is met

- The clinical care manager verifies that the CON is properly executed.
- The clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is met, but the request exceeds the maximum time allowed for the service, the age of the recipient for whom the service is intended determines the disposition of the request.

- If the service authorization request is for a recipient aged 21 or older, the clinical care manager authorizes treatment/service for the maximum time allowable and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

- If the service authorization request is for a recipient under the age of 21, the LME UM medical director reviews the request using EPSDT criteria.
  - ♦ If the service authorization request meets the EPSDT criteria, the clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

Where applicable, if the CON is not received or is not properly executed, the authorization is pended (see **Section X.B.**).

If the clinical care manager determines that medical necessity is not met, the LME contacts the treating clinician/service provider regarding a person centered plan that meets medical necessity (see **Section X.C.**).

- If an agreement cannot be reached regarding treatment, the case is forwarded to the LME UM medical director for peer review.
- If the service authorization request is for a recipient under the age of 21, the LME UM medical director reviews the request using EPSDT criteria.
- The LME UM medical director may contact the treating clinician/service provider to consult on the person centered plan.

If the review results in a determination that medical necessity is met, then the care is authorized.

- The clinical care manager authorizes treatment and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the review results in a determination that medical necessity may be met by reducing or authorizing alternative treatment/service,

- The clinical care manager contacts the treating clinician/service provider to discuss revising the treatment/service plan.
- If the treating clinician/service provider agrees with the revisions, the clinical care manager documents the discussion in the record.
- The service provider must obtain approval from the recipient for the revised treatment/service plan.
- The authorization request is pended (see **Section X.B.**) until the service provider notifies the clinical care manager of the recipient's approval. This must be received within fifteen (15) business days.

**Note:** If the recipient's approval is not obtained the request must be denied, reduced, terminated, or suspended on day 16.

- Upon receipt of the recipient's approval, the LME documents the record.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If it is determined that medical necessity is not met or an agreement to revise the treatment/service plan to meet medical necessity cannot be reached, the LME must deny, reduce, or terminate the service (see **Section X.E.**).

- The LME must notify the treating clinician/service provider by telephone on the day the adverse action is completed.
- A detailed written notification of the action (see **Section XI.**) must also be sent to the service provider and the recipient and/or his/her legal representative the treating clinician/service provider within one (1) business day.
- The LME must post the adverse action notice to the DMH/OAH secure website.

## **2. Concurrent Reviews for Re-authorization Requests**

The service facility contacts the LME to provide a clinical update prior to the expiration of the current authorization period in order to obtain approval for additional care. The LME must respond within the timeframes specified in **Section VII.H.**

If the service facility is requesting authorization for admission of a recipient under the age of 21 to a free-standing psychiatric facility (**hospital/psychiatric residential treatment facility**), the LME requests a CON (<http://www.ncdhhs.gov/dma/formsprov.html#bh>) from the service provider.

If the clinical care manager determines that the request meets any of the criteria for denial due to administrative reasons (see **Section X.D.**)

- The clinical care manager does NOT review the request for medical necessity.
- The clinical care manager documents the denial (see **Section X.D.**).
- A written notification of the denial must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

The clinical care manager reviews the clinical information and determines if medical necessity is met based on approved Medicaid criteria and policy.

If the clinical care manager determines that medical necessity is met

- The clinical care manager verifies that the CON is properly executed.
- The clinical care manager authorizes treatment and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is met, but the request exceeds the maximum time allowed for the service, the age of the recipient for whom the service is intended determines the disposition of the request.

- If the service authorization request is for a recipient aged 21 or older, the clinical care manager authorizes treatment/service for the maximum time allowable and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.
- If the service authorization request is for a recipient under the age of 21, the LME UM medical director reviews the request using EPSDT criteria.
  - ♦ If the service authorization request meets the EPSDT criteria, the clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

Where applicable, if the CON is not received or is not properly executed, the authorization is pended (see **Section X.B.**).

If the clinical care manager determines that medical necessity is not met, the LME contacts the treating clinician/service provider regarding a person centered plan that meets medical necessity (see **Section X.C.**).

- If an agreement cannot be reached regarding treatment, the case is forwarded to the LME UM medical director for peer review.
- If the service authorization request is for a recipient under the age of 21, the LME UM medical director reviews the request using EPSDT criteria.
- The LME UM medical director may contact the treating clinician/service provider to consult on the person centered plan.

If the review results in a determination that medical necessity is met, then the care is authorized.

- The clinical care manager authorizes treatment and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the review results in a determination that medical necessity may be met by reducing or authorizing alternative treatment/service,

- The clinical care manager contacts the treating clinician/service provider to discuss revising the treatment/service plan.
- If the treating clinician/service provider agrees with the revisions, the clinical care manager documents the discussion in the record.
- The service provider must obtain approval from the recipient for the revised treatment/service plan.
- The authorization request is pended (see **Section X.B.**) until the service provider notifies the clinical care manager of the recipient's approval. This must be received within fifteen (15) business days.

**Note:** If the recipient's approval is not obtained the request must be denied, reduced, terminated, or suspended on day 16.

- Upon receipt of the recipient's approval, the LME documents the record.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If it is determined that medical necessity is not met or an agreement to revise the treatment/service plan to meet medical necessity cannot be reached, the LME must deny, reduce, or terminate the service (see **Section X.E.**).

- The LME must notify the treating clinician/service provider by telephone on the day the adverse action is completed.
- A detailed written notification of the action (see **Section XI.**) must also be sent to the service provider and the recipient and/or his/her legal representative the treating clinician/service provider within one (1) business day.
- The LME must post the adverse action notice to the DMH/OAH secure website.
- Where applicable, the LME must issue maintenance of services authorization (see **Section XIII.**).

**D. Residential Child Care Treatment (Levels I through IV) Facility Services and Therapeutic Foster Care**

**1. Initial Authorization Reviews**

The authorization process is initiated when the service provider submits a completed Service Request Form to the LME. The LME must respond within the timeframes specified in **Section VII.G**. The LME reviews the form to verify that the request includes the required information and documentation listed in **Section VII.E**.

The LME must confirm that the enrolled service provider is licensed and endorsed to provide the level of care that is being requested for the recipient and must indicate the appropriate State-created procedure code on the authorization (see **Section VII.D**).

If the clinical care manager determines that the request meets any of the criteria for denial due to administrative reasons (see **Section X.D**.)

- The clinical care manager does NOT review the request for medical necessity.
- The clinical care manager documents the denial (see **Section X.D**).
- A written notification of the denial must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is met

- The clinical care manager authorizes treatment and documents the approval (see **Section X.A**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is met, but the request exceeds the maximum time allowed for the service, the age of the recipient for whom the service is intended determines the disposition of the request.

- If the service authorization request is for a recipient aged 21 or older, the clinical care manager authorizes treatment/service for the maximum time allowable and documents the approval (see **Section X.A**).
- ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

- If the service authorization request is for a recipient under the age of 21, the LME UM medical director reviews the request using EPSDT criteria.
  - ♦ If the service authorization request meets the EPSDT criteria, the clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is not met, the LME contacts the treating clinician/service provider regarding a treatment plan that meets medical necessity (see **Section X.C.**).

- If an agreement cannot be reached regarding treatment/service, the case is forwarded to the LME UM medical director for peer review.
- If the service authorization request is for a recipient under the age of 21, the LME UM medical director reviews the request using EPSDT criteria.
- The LME UM medical director may contact the treating clinician/service provider to consult on the treatment plan.

If the review results in a determination that medical necessity is met, then the care is authorized.

- The clinical care manager authorizes treatment and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the review results in a determination that medical necessity may be met by reducing or authorizing alternative treatment services,

- The clinical care manager contacts the treating clinician/service provider to discuss revising the treatment/service plan.
- If the treating clinician/service provider agrees with the revisions, the clinical care manager documents the discussion in the record.
- The service provider must obtain approval from the recipient for the revised treatment/service plan.
- The authorization request is pended (see **Section X.B.**) until the service provider notifies the clinical care manager of the recipient's approval. This must be received within fifteen (15) business days.

**Note:** If the recipient's approval is not obtained the request must be denied, reduced, terminated, or suspended on day 16.

- Upon receipt of the recipient's approval, the LME documents the record.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If it is determined that medical necessity is not met or an agreement to revise the treatment/service plan to meet medical necessity cannot be reached, the LME must deny, reduce, or terminate the service (see **Section X.E.**).

- The LME must notify the treating clinician/service provider by telephone on the day the adverse action is completed.
- A detailed written notification of the action (see **Section XI.**) must also be sent to the service provider and the recipient and/or his/her legal representative the treating clinician/service provider within one (1) business day.
- The LME must post the adverse action notice to the DMH/OAH secure website.

## **2. Concurrent Reviews for Re-authorization Requests**

The re-authorization process is initiated when the service provider submits a completed Service Request Form and updated clinical information to the LME. The LME must respond within the timeframes specified in **Section VII.H.**

If the clinical care manager determines that the request meets any of the criteria for denial due to administrative reasons (see **Section X.D.**)

- The clinical care manager does NOT review the request for medical necessity.
- The clinical care manager documents the denial (see **Section X.D.**).
- A written notification of the denial must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is met

- The clinical care manager authorizes treatment and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is met, but the request exceeds the maximum time allowed for the service, the age of the recipient for whom the service is intended determines the disposition of the request.

- If the service authorization request is for a recipient aged 21 or older, the clinical care manager authorizes treatment/service for the maximum time allowable and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.
- If the service authorization request is for a recipient under the age of 21, the LME UM medical director reviews the request using EPSDT criteria.
  - ♦ If the service authorization request meets the EPSDT criteria, the clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is not met, the LME contacts the treating clinician/service provider regarding a treatment plan that meets medical necessity (see **Section X.C.**).

- If an agreement cannot be reached regarding treatment, the case is forwarded to the LME UM medical director for peer review.
- If the service authorization request is for a recipient under the age of 21, the LME UM medical director reviews the request using EPSDT criteria.
- The LME UM medical director may contact the treating clinician/service provider to consult on the treatment plan.

If the review results in a determination that medical necessity is met, then the care is authorized.

- The clinical care manager authorizes treatment and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the review results in a determination that medical necessity may be met by reducing or authorizing alternative treatment services,

- The clinical care manager contacts the treating clinician/service provider to discuss revising the treatment/service plan.
- If the treating clinician/service provider agrees with the revisions, the clinical care manager documents the discussion in the record.
- The service provider must obtain approval from the recipient for the revised treatment/service plan.
- The authorization request is pending (see **Section X.B.**) until the service provider notifies the clinical care manager of the recipient's approval. This must be received within fifteen (15) business days.

**Note:** If the recipient's approval is not obtained the request must be denied, reduced, terminated, or suspended on day 16.

- Upon receipt of the recipient's approval, the LME documents the record.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If it is determined that medical necessity is not met or an agreement to revise the treatment/service plan to meet medical necessity cannot be reached, the LME must deny, reduce, or terminate the service (see **Section X.E.**).

- The LME must notify the treating clinician/service provider by telephone on the day the adverse action is completed.
- A detailed written notification of the action (see **Section XI.**) must also be sent to the service provider and the recipient and/or his/her legal representative the treating clinician/service provider within one (1) business day.
- The LME must post the adverse action notice to the DMH/OAH secure website.
- Where applicable, the LME must issue maintenance of services authorization (see **Section XIII.**).

#### **E. Criterion 5 Services**

When a recipient under the age of 17 meets discharge criteria but placement is not available in the community, the recipient's treating clinician/service provider must request continuation of service under Criterion 5.

The service provider must submit the Criterion 5 Services Needs/Discharge Planning Status Form with a copy of the discharge plan attached to the form.

The LME must respond within the timeframes specified in **Section VII.G.**

If the request for Criterion 5 is incomplete (e.g., missing discharge plan)

- The LME notifies the service facility that correct information is required
- The authorization request is pended (see **Section X.B.**) until the service provider notifies the clinical care manager of the recipient's approval. This must be received within fifteen (15) business days.

**Note:** If the recipient's approval is not obtained the request must be denied, reduced, terminated, or suspended on day 16.

If the request for Criterion 5 is complete

- The LME clinical care manager reviews the request and determines if placement is available or appropriate.

If the LME clinical care manager determines that placement is not available or appropriate

- Criterion 5 is certified for the dates of service until discharge and an authorization letter is issued.
- The letter is sent to the legal representative(s) advising them of the recipient's eligibility for Criterion 5.
- The clinical care manager faxes a continued stay form to the facility on the day that the request is approved.
- A written notification of the approval and the continued stay form must be mailed to the service provider within one (1) business day.

The clinical care manager monitors the continued stay through weekly reports from the recipient's treating clinician while prospective placement is located.

## **F. CAP/MR-DD and Targeted Case Management**

### **1. Initial Authorization Requests**

Authorization of service is required for recipients who are eligible for participation in the CAP/MR-DD waiver program or to receive targeted case management services.

Authorization may also be requested if a recipient's eligibility is suspended (e.g., hospitalization, incarceration) and is then reinstated.

If the total funding requested exceeds \$100,000, the authorization request must be forwarded to DMH for their review of the recipient's person centered plan.

The authorization process is initiated when the service provider submits a completed Service Request Form to the LME. The LME must respond within the timeframes specified in **Section VII.G.** The LME reviews the form to verify that the request includes the required information and documentation listed in **Section VII.E.**

The LME clinical care manager reviews the clinical information and determines if medical necessity is met based on approved Medicaid criteria and policy.

If the clinical care manager determines that the request meets any of the criteria for denial due to administrative reasons (see **Section X.D.**)

- The clinical care manager does NOT review the request for medical necessity.
- The clinical care manager documents the denial (see **Section X.D.**).
- A written notification of the denial must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the LME clinical care manager determines that medical necessity is met

- The LME clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is met, but the request exceeds the maximum time allowed for the service, the age of the recipient for whom the service is intended determines the disposition of the request.

- If the service authorization request is for a recipient aged 21 or older, the clinical care manager authorizes treatment/service for the maximum time allowable and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.
- If the service authorization request is for a recipient under the age of 21, the LME clinical care manager reviews the request using EPSDT criteria.
  - ♦ If the service authorization request meets the EPSDT criteria, the clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the LME clinical care manager determines that medical necessity is not met, the LME contacts the treating clinician/service provider regarding a person centered plan that meets medical necessity (see **Section X.C.**).

If the service authorization request is for a recipient under the age of 21, the LME clinical care manager reviews the request using EPSDT criteria.

If the review results in a determination that medical necessity is met, then the care is authorized.

- The LME clinical care manager authorizes treatment and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the review results in a determination that medical necessity may be met by reducing or authorizing alternative treatment services,

- The clinical care manager contacts the treating clinician/service provider to discuss revising the treatment/service plan.
- If the treating clinician/service provider agrees with the revisions, the clinical care manager documents the discussion in the record.
- The service provider must obtain approval from the recipient for the revised treatment/service plan.
- The authorization request is pended (see **Section X.B.**) until the service provider notifies the clinical care manager of the recipient's approval. This must be received within fifteen (15) business days.

**Note:** If the recipient's approval is not obtained the request must be denied, reduced, terminated, or suspended on day 16.

- Upon receipt of the recipient's approval, the LME documents the record.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If it is determined that medical necessity is not met or an agreement to revise the treatment/service plan to meet medical necessity cannot be reached, the case is referred to the LME UM medical director or licensed psychologist for peer review. If the LME UM medical director or psychologist agrees that medical necessity is not met, the LME must deny, reduce, or terminate the service (see **Section X.E.**).

- The LME must notify the treating clinician/service provider by telephone on the day the adverse action is completed.
- A detailed written notification of the action (see **Section XI.**) must also be sent to the service provider and the recipient and/or his/her legal representative the treating clinician/service provider within one (1) business day.
- The LME must post the adverse action notice to the DMH/OAH secure website.

## 2. **Concurrent Reviews for Re-authorization Requests**

Concurrent reviews for re-authorizations of CAP/MR-DD services and targeted case management must be performed once annually on or about the anniversary of the birth month of the recipient.

The re-authorization process is initiated when the service provider submits a completed Service Request Form and updated Person Centered Plan with clinical information to the LME. The LME must respond within the timeframes specified in **Section VII.H.**

If the clinical care manager determines that the request meets any of the criteria for denial due to administrative reasons (see **Section X.D.**)

- The clinical care manager does NOT review the request for medical necessity.
- The clinical care manager documents the denial (see **Section X.D.**).
- A written notification of the denial must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the LME clinical care manager determines that medical necessity is met

- The LME clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is met, but the request exceeds the maximum time allowed for the service, the age of the recipient for whom the service is intended determines the disposition of the request.

- If the service authorization request is for a recipient aged 21 or older, the clinical care manager authorizes treatment/service for the maximum time allowable and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.
- If the service authorization request is for a recipient under the age of 21, the LME clinical care manager reviews the request using EPSDT criteria.
  - ♦ If the service authorization request meets the EPSDT criteria, the clinical care manager authorizes treatment/service and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the LME clinical care manager determines that medical necessity is not met, the LME contacts the treating clinician/service provider regarding a person centered plan that meets medical necessity (see **Section X.C.**).

If the service authorization request is for a recipient under the age of 21, the LME clinical care manager reviews the request using EPSDT criteria.

If the review results in a determination that medical necessity is met, then the care is authorized.

- The LME clinical care manager authorizes treatment and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the review results in a determination that medical necessity may be met by reducing or authorizing alternative treatment services,

- The clinical care manager contacts the treating clinician/service provider to discuss revising the treatment/service plan.
- If the treating clinician/service provider agrees with the revisions, the clinical care manager documents the discussion in the record.
- The service provider must obtain approval from the recipient for the revised treatment/service plan.
- The authorization request is pended (see **Section X.B.**) until the service provider notifies the clinical care manager of the recipient's approval. This must be received within fifteen (15) business days.

**Note:** If the recipient's approval is not obtained the request must be denied, reduced, terminated, or suspended on day 16.

- Upon receipt of the recipient's approval, the LME documents the record.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If it is determined that medical necessity is not met or an agreement to revise the treatment/service plan to meet medical necessity cannot be reached, the case is referred to the LME UM medical director or licensed psychologist for peer review. If the LME UM medical director or psychologist agrees that medical necessity is not met, the LME must deny, reduce, or terminate the service (see **Section X.E.**).

- The LME must notify the treating clinician/service provider by telephone on the day the adverse action is completed.
- A detailed written notification of the action (see **Section XI.**) must also be sent to the service provider and the recipient and/or his/her legal representative the treating clinician/service provider within one (1) business day.
- The LME must post the adverse action notice to the DMH/OAH secure website.
- Where applicable, the LME must issue maintenance of services authorization (see **Section XIII.**).

**G. Out-of-State Services**

The authorization process is initiated when the service provider submits a completed Out-of-State Placement Packet (<http://www.ncdhhs.gov/mhddsas/statpublications/manualsforms/forms/forms-outofstplacement.pdf>) to the LME. The LME must respond within the timeframes specified in **Section VII.G**. The LME reviews the form to verify that the request includes the required information and documentation listed in **Section VII.E**.

The LME clinical care manager reviews the clinical information and determines if medical necessity is met based on approved Medicaid criteria and policy.

If the clinical care manager determines that medical necessity is met

- The LME contacts the service provider to determine if there are alternative facilities in North Carolina appropriate to meet the needs of the recipient.
- If there are no appropriate facilities in North Carolina, the LME contacts the DMA Behavioral Health Services Unit with the recommendation to approve the service.
- DMA issues written approval to the LME upon verification by DMA that the out-of-state provider meets enrollment criteria, has agreed to the assigned rate of payment, has agreed to accept the recipient, and has been assigned a Medicaid provider number.
- The clinical care manager authorizes treatment and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is met but the provision of service out-of-state does not appear to be appropriate, the LME contacts DMA to consult on the authorization request.

- If DMA directs the LME to approve the service, then care can be authorized.
  - ♦ DMA issues written approval to the LME upon verification by DMA that the out-of-state provider meets enrollment criteria and has been assigned a Medicaid provider number.
  - ♦ The clinical care manager authorizes treatment and documents the approval (see **Section X.A.**).
  - ♦ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.
- If DMA concurs with the LME, the LME must deny, reduce, or terminate the service (see **Section X.E.**).
  - ♦ The LME must notify the treating clinician/service provider by telephone on the day the adverse action is completed.
  - ♦ A detailed written notification of the action (see **Section XI.**) must also be sent to the service provider and the recipient and/or his/her legal representative the treating clinician/service provider within one (1) business day.
  - ♦ The LME must post the adverse action notice to the DMH/OAH secure website.

#### H. **Services Approved through EPSDT Reviews**

EPSDT criteria reviews should be completed using the EPSDT Request Clinical Review Form (see **Attachment I**). EPSDT reviews must be completed within the timeframes specified in **Section VII.G**.

EPSDT reviews may be initiated by

- DMA.
- A service authorization request for a recipient under the age of twenty-one (21) that was denied through the utilization review process because it exceeded unit or visit limitations or age exclusions as delineated in the service definitions or clinical coverage policies for the service.

If the request for service is incomplete,

- the LME notifies the service provider that correct information is required
- the authorization is pended (see **Section X.B.**)

The clinical care manager reviews the clinical information to determine if medical necessity is met based on EPSDT criteria.

If the clinical care manager determines that medical necessity is met:

- The clinical care manager authorizes treatment and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that medical necessity is not met, the LME contacts the treating clinician/service provider regarding a treatment plan that meets medical necessity (see **Section X.C.**).

- If an agreement cannot be reached regarding treatment, the case is forwarded to the LME UM medical director for peer review.
- The LME UM medical director may contact the treating clinician/service provider to consult on the treatment plan.

If the review results in a determination that medical necessity is met, then the care is authorized.

- The clinical care manager authorizes treatment and documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the review results in a determination that medical necessity may be met by reducing or authorizing alternative treatment services,

- The clinical care manager contacts the treating clinician/service provider to discuss revising the treatment/service plan.
- If the treating clinician/service provider agrees with the revisions, the clinical care manager documents the discussion in the record.
- The service provider must obtain approval from the recipient for the revised treatment/service plan.

- The authorization request is pended (see **Section X.B.**) until the service provider notifies the clinical care manager of the recipient's approval. This must be received within fifteen (15) business days.  
**Note:** If the recipient's approval is not obtained the request must be denied, reduced, terminated, or suspended on day 16.
- Upon receipt of the recipient's approval, the LME documents the record.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If it is determined that medical necessity is not met or an agreement to revise the treatment/service plan to meet medical necessity cannot be reached, the LME must deny, reduce, or terminate the service (see **Section X.E.**).

- The LME must notify the treating clinician/service provider by telephone on the day the adverse action is completed.
- A detailed written notification of the action (see **Section XI.**) must also be sent to the service provider and the recipient and/or his/her legal representative the treating clinician/service provider within one (1) business day.
- The LME must post the adverse action notice to the DMH/OAH secure website.
- Where applicable, the LME must issue maintenance of services authorization (see **Section XIII.**).

#### **I. Services Approved through Retrospective Reviews**

If it is determined that a request for a retrospective review was submitted in a timely manner (see **Section VIII.E.**), the LME requests the complete record for the dates of service in question.

Upon receipt of the Service Request Form and the medical records, the clinical care manager determines if medical necessity has been met. Retrospective reviews must be completed within the timeframes specified in **Section VII.I.**

If the clinical care manager determines that the request meets any of the criteria for denial due to administrative reasons (see **Section X.D.**)

- The clinical care manager does NOT review the request for medical necessity.
- The clinical care manager documents the denial (see **Section X.D.**).
- A written notification of the denial must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager determines that, based on Medicaid criteria, medical necessity is met, the entire episode of care is certified.

- The clinical care manager documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If the clinical care manager cannot determine medical necessity for all or a portion of the stays, the case is forwarded to the LME UM medical director for peer review.

If the review results in a determination that medical necessity was met, then the care is authorized.

- The clinical care manager documents the approval (see **Section X.A.**).
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

If it is determined that medical necessity is not met or an agreement to revise the treatment/service plan to meet medical necessity cannot be reached, the LME must deny, reduce, or terminate the service (see **Section X.E.**).

- The LME must notify the treating clinician/service provider by telephone on the day the adverse action is completed.
- A detailed written notification of the action (see **Section XI.**) must also be sent to the service provider and the recipient and/or his/her legal representative the treating clinician/service provider within one (1) business day.
- The LME must post the adverse action notice to the DMH/OAH secure website.

## **X. DISPOSITION OF AUTHORIZATION REQUESTS**

### **A. Approval**

If the requested service is determined to be medically necessary, the LME authorizes care issuing a written authorization/decision letter to the service provider and the recipient and/or his/her legal representative within one (1) business day.

The LME must issue a letter of approval using a letter format (see **Attachment J**) approved by DMA that is appropriate to the request.

<b>Type of Review</b>	<b>Notice</b>	<b>Description</b>
Initial Review Concurrent Review Retrospective Review	DMA 3504	Request was approved as meeting medical necessity criteria.
Initial Review Concurrent Review EPSDT Review Retrospective Review	DMA3504E	Request was approved as meeting medical necessity criteria (clinical and EPSDT) for recipient under the age of 21.
Initial Review Concurrent Review EPSDT Review Retrospective Review	DMA 1059	Request was approved for maximum time allowed by service definition or clinical coverage policy.

**B. Pended Requests**

When a service provider's request for authorization does not contain the required data elements for a valid authorization request, including missing and/or incorrect information, the request is pended and the LME notifies the service provider that additional information is required to complete the service authorization review.

The request for additional information must be made by phone and followed by a written information request within one (1) business day.

The LME must request additional information using a letter format (see **Attachment J**) approved by DMA.

Type of Review	Notice	Description
Initial Review Concurrent Review EPSDT Review Retrospective Review	DMA 3501	Additional information required to determine if service meets medical necessity for a recipient 21 years of age and older.
	DMA 3501E	Additional information required to determine if service meets medical necessity criteria (clinical and EPSDT) for recipient under 21 years of age.

If the provider does not respond to the request within fifteen (15) business days following the issuance of the request by submitting the needed information or requesting a time extension, the LME must make a decision based on the information available.

If the service authorization request is denied, the LME must issue a letter of denial informing the service provider that the service authorization request was denied due to the service provider's failure to provide the additional information. The LME must use a letter format (see **Attachment J**) approved by DMA.

Type of Review	Notice	Description
Initial Review Concurrent Review EPSDT Review Retrospective Review	DMA 2001A	Request was denied due to failure to provide additional requested information

**C. Revisions to the Original Request Resulting in a Change in Service**

The LME may discuss with the service provider an alternative volume, duration or combination of services from that which was requested.

The service provider is responsible for reviewing the changes with the recipient and/or his/her legal representative and, if appropriate, with the recipient's treating clinician. The service provider may submit a revised person centered plan with the consent of the recipient/guardian indicated (by signature) in the person centered plan along with an authorization request, if indicated, for the alternatives service(s) discussed and/or a referral to an appropriate service provider for the alternative service.

The LME must retain documentation of the negotiated changes in the requested services for review by DMA, the recipient/guardian, and applicable service provider.

The LME must issue an authorization letter reflecting this change of service using a letter format (see **Attachment J**) approved by DMA.

Type of Review	Notice	Description
Initial Review EPSDT Review	DMA 2001	Request was reduced or changed.
	DMA 2001E	Request reviewed under EPSDT criteria was reduced or changed.
Concurrent Review EPSDT Review Retrospective Review	DMA 2002	Request was reduced or changed.
	DMA 2002E	Request reviewed under EPSDT criteria was reduced or changed.

If an agreement cannot be reached, the service authorization request is denied (see **Section X.E.**).

#### **D. Administrative Denials**

Denials based on an administrative regulation that does not include consideration of medical necessity (e.g., benefit limits and documentation requirements) may be made by the LME UM staff qualified to render clinical decisions pursuant to this policy (see **Section IV.**).

These types of notifications do not require the LME to issue appeal information to the recipient.

##### **1. Missing or Incorrect Information**

When a service provider's request for authorization does not contain the required data elements for a valid authorization request, including missing and/or incorrect information, the request must be returned to the service provider. These notifications do not require the LME to issue appeal information to the recipient.

**For all recipients**, the recipients Medicaid identification number, the provider's Medicaid provider number, the service requested, and the diagnosis code must be indicated on the request form. Also, the request must be for a recipient in the LME's catchment area. If any of this information is not present, the LME returns the request to the service provider as "Unable to Process."

**For recipients ages 21 and older**, if the person centered plan and/or supporting documentation is incomplete, the LME returns the request to the service provider as "Unable to Process."

The LME must issue a letter of denial using a denial letter format (see **Attachment J**) approved by DMA.

Type of Review	Notice	Description
Initial Review Concurrent Review Retrospective Review	DMA 3503	Request was returned to provider with no action taken

**For a recipient under the age of 21**, if the person centered plan and/or supporting documentation is incomplete, return the form for “Lack of Information” and give the provider 15 days to return the requested information. If the information is not returned within 15 days, deny the request as an “Administrative Denial.”

The LME must request additional information using a letter format (see **Attachment J**) approved by DMA.

Type of Review	Notice	Description
Initial Review Concurrent Review EPSDT Review Retrospective Review	DMA 3501	Additional information required to determine if service meets medical necessity
	DMA 3501E	Additional information required to determine if service meets EPSDT criteria

## 2. Duplicate Requests

If it is determined that the authorization requests is a duplicate of a requests already received

- If no action has been taken on the initial request, return the duplicate request and indicate that no action was taken because the request was a duplicate.
- If the request has been reviewed and approved, return the duplicate request to the provider and indicate that no action was taken because the request was a duplicate.
- If the request has been reviewed and adverse action was taken, review the request to see if additional information is contained in the request that would change the adverse decision. If there is no change in the adverse action, return the duplicate request to the service provider indicating that the initial decision stays; no appeal rights should be granted.
- If the appeal rights have expired, review the request as a new request. Appeal rights are implicated if adverse action is taken.

The LME must issue a letter of denial using a denial letter format (see **Attachment J**) approved by DMA.

Type of Review	Notice	Description
Initial Review Concurrent Review Retrospective Review	DMA 3503	Request was returned to provider with no action taken

### 3. **Requests for Services that are Currently Authorized to Another Provider**

The LME may not authorize a service for a recipient during any active authorization period for this same service with another service provider. The LME must receive the completed Discharge from Treatment Form (see **Attachment K**) for this service from the service provider with the active authorization. If the LME receives a request for services from a provider for a recipient with an active authorization for that service, the service request will be denied for administrative reasons.

The LME must issue a letter of denial using a denial letter format (see **Attachment J**) approved by DMA.

Type of Review	Notice	Description
Initial Review Concurrent Review Retrospective Review	DMA 3503	Request was returned to provider with no action taken

### E. **Denial/Reduction**

The LME may deny a request for services if it is determined that

- medical necessity criteria is not met for the specific service requested
- medical necessity criteria is not met for the volume or duration of the specific service requested
- the services would be ineffective
- a more cost-effective alternative that otherwise satisfies the standards for medically necessary services is available
- the services exceeds benefit limits (if 21 years of age or older only)
- the service provider failed to provide a complete authorization request form or failed to provide additional information as requested
- other administrative reasons

Authorization requests that are denied due to lack of medical necessity must be issued by appropriate clinical staff as defined in **Section IV.F**.

In the event that the recipient has medical issues involved with the presenting problems, the recipient's treating clinician must be consulted prior to issuance of any denial or recommendation of alternative service.

If the denial is appealed, the LME will issue Maintenance of Service authorization (see **Section XIII.**) within the timeframes designated by the appeal process.

The LME must document the following information in the review record for authorization requests that are denied due to lack of medical necessity:

- specific service units and/or time period denied
- the reason for the denial
- any alternative services that are recommended based on evidence-based treatment standards

The LME must notify the individual and/or his/her legal representative (if any) by trackable mail with return receipt requested; the provider by regular mail or courier; and DMA electronically as specified by DMA.

The LME must issue a letter of denial using a denial letter format (see **Attachment J**) approved by DMA within the timeframes designated by the appeal process.

Type of Review	Notice	Description
Initial Review EPSDT Review	DMA 2001	Request was denied.
	DMA 2001E	Request reviewed under policy and EPSDT criteria and denied under EPSDT.
Concurrent Review EPSDT Review Retrospective Review	DMA 2002	Request was denied.
	DMA 2002E	Request reviewed under policy and EPSDT criteria and denied under EPSDT.

An explanation of the individual's appeal rights and a statement of the manner in which the individual may appeal the adverse determination must be included in the letter. An appeal request form must be included in the letter to the recipient and/or his/her legal representative. (See **Section XI**. for additional information.)

## **XI. NOTIFICATION OF ADVERSE ACTIONS**

### **A. Recipient Notices**

When an adverse decision is made to deny, reduce (change), terminate, or suspend a Medicaid applicant's or recipient's services, the recipient and/or his/her legal representative, where applicable, must be notified in writing by trackable mail of the decision.

The reason for the adverse action must be stated clearly in the notice and it must be specific to the recipient. For example, if medical necessity is not met, the clinician must state why medical necessity was not met.

The citations that support the decision must be specific [for example, 8A (3.1)(e)(3)]. It is not acceptable to cite only policy 8A. If the recipient is under 21 years of age, specify both the EPSDT and clinical coverage policy criteria that are not met.

The LME must complete all of the highlighted section in the header portion of the Recipient Hearing Request Form (DMA 2003) (see **Attachment L**) and mail it, along with the general information sheet about the hearing process and appeal form, to the recipient or guardian. Should the recipient be under 21 years of age or adjudicated incompetent, the notice must be mailed to the recipient's legal representative.

**Note:** The general information sheet and recipient request form cannot be duplexed. They must be mailed as one page documents.

While DMA would prefer that the name of the clinician making the decision appear on the notice, it is permissible to use a more generic signature. See the example below.

Prior Approval Unit, LME  
Fiscal Agent for the North Carolina Division of Medical Assistance  
(Medicaid)

When the LME mails the notice to the recipient and/or his/her legal representative the notice will also be posted to the DMH/OAH secure website.

**Note:** LMEs will receive additional information regarding this process at a later date.

**B. Notice Format**

The notices provided are specific to DMA. The LME must customize the notices for their use. The notices must be reproduced on the LME's letterhead.

In the body of some of the notices, DMA's mailing address and telephone numbers are provided; the LME must insert appropriate contact information. All highlighted, bracketed information, and examples must be completed and customized to the individual recipient. No other changes should be made to the notices.

Information that is not applicable to the recipient must be removed from the notices.

The Spanish translation on page 1 of the DMA 2001, 2001A, 2001E, 2002, and 2002E must be maintained in the footer on that page.

**Note:** Spanish translations of the notices will follow at a later date. Until the Spanish notices are available, mail the English version of the notice.

**C. Date of Notification**

If the adverse action is related to an initial request for services, the date of the notice is the date the notice is mailed. This cannot be the date the notice is picked-up by the mailing vendor unless the notice is mailed that day as well. The effective date is the day the notice is mailed.

If the adverse action is related to a re-authorization request the effective date of the adverse action is 30 days from the date the notice is to be mailed.

**D. Tracking Notifications**

In regard to mailing the notice, a trackable system must be used to mail the notices. If the notice is returned, the LME must provide for retention, security, and destruction of the notice in accordance with all applicable federal and state laws, rules, and regulations.

**E. Notification Audits**

At a minimum, ten percent (10%) of the notifications generated as the result of an adverse action (denial, termination, reduction) must be audited by the LME on a monthly basis to verify the accuracy and timely notification of adverse actions.

The audit is used to verify that

- the adverse determination letter was generated;
- the appropriate adverse determination letter was used;
- the adverse determination letter accurately reflected the decision of the LME's UM medical director, including decision, alternative recommendations, denial reason, and supporting citation;
- the adverse determination letter was appropriately addressed per the DMA provided consumer and provider demographic information; and
- MOS was posted accurately and within 48 hours as the appeal progressed through the various phases/stages.

The LME must report the findings of the audit to DMA on a monthly basis (see **Section XX.C.**). DMA reserves the right to audit notifications as it deems necessary to assure quality.

**XII. HEARING AND APPEALS****A. Filing for a Hearing with the Office of Administrative Hearings**

The recipient, legal representative, or a spokesperson designated in writing or verbally by the recipient or his/her legal representative have the right to appeal to the Office of Administrative Hearings (OAH).

To file the request, the Recipient Hearing Request Form (DMA 2003) must be completed, signed, dated, and faxed or mailed to **both** DHHS and OAH as specified on the form. The request must be filed within 30 days of the date the notice was mailed. The recipient's case will commence as soon as the completed recipient hearing request form is **received and filed** with OAH **AND** DHHS.

Refer to **Attachment M** for the Medicaid Recipient Fair Hearing Timeline.

**B. Hearing Process**

Once the request for hearing is filed, the recipient, legal representative or spokesperson will be contacted by OAH or the Mediation Network of North Carolina to discuss their case and to be offered an opportunity for mediation in an effort to resolve the appeal.

If mediation resolves the case, the hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina. If the offer of mediation or the results of mediation are not accepted, the case will proceed to hearing and will be heard by an administrative law judge with OAH. The recipient, legal representative or spokesperson will be notified by mail of the date, time, and location of the hearing.

The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. The recipient, legal representative or spokesperson will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision. If the recipient or legal representative does not agree with Medicaid's final agency decision, a judicial review in superior court may be requested. The hearing process must be completed within ninety (90) days of receipt of the completed Recipient Hearing Request Form.

**C. Responsibilities of LME For Appeals and Hearings**

The LME must maintain and store all relevant documentation, which includes, but is not limited to

- pertinent medical records to substantiate the adverse decision
- provider records of prior and concurrent treatment
- any LME records
- a written narrative of the LME's reasons to deny services to an individual, including citations to support the decision
- copies of the adverse notice and Recipient Hearing Request Form

The LME will be notified when a request for hearing has been received. If the recipient is eligible for MOS, the LME will enter the MOS within 48 hours as the appeal progresses and will contact the service provider regarding provision of services for the pendency of the appeal.

A qualified LME representative (a child/adolescent psychiatrist if the recipient is under 21 or an adult psychiatrist if over 21 or a professional specializing in the MH/SA/DD disability of the recipient) must represent DMA at the OAH proceedings.

Other qualified staff members must be available for reviews, interviews and testimony for mediation and hearings. Representation during mediation includes

- explaining why the adverse decision was made
- offering acceptable compromise options
- reviewing any new information presented, and changing the previous decision if necessary
- accepting or rejecting the mediator's resolution to the case
- entering the mediator's order into the authorization system if mediation resolution accepted
- notifying the provider of the outcome

Additionally, if the case goes to hearing, the LME is expected to testify, and, if the case goes to judicial review, the LME must provide information as requested by either the DMA Appeals Coordinator or Attorney General.

The LME will be notified regarding the final agency decision and/or judicial review. The LME is expected to notify the service provider about the hearing outcome and provision of service.

### **XIII. Maintenance of Service**

A recipient is entitled to MOS if he/she had been receiving services the day the decision was made and as long as he/she remains otherwise Medicaid eligible, unless they give up this right, for the pendency of the appeal. **This right to receive services applies even if the recipient changes providers.**

A new service request is not required until the appeal is completed. However, the services must be provided in accordance with all federal and state applicable laws and rules and regulations. Services will be provided at the same level the recipient was receiving the day before the decision or the level requested by the provider, whichever is less. The services that continue must be based on the recipient's current condition. If the recipient loses his/her appeal, he/she may be required to pay for the services that continue because of the appeal.

**Note:** The LME will receive additional information at a later date regarding how to submit a Prior Approval request for the MOS time period.

### **XIV. LME Quality Improvement and Performance Standards**

#### **A. Objectives**

The LME must have a quality improvement plan in place to monitor and assure the accuracy of their authorization decisions and the ongoing application of appropriate parameters, regulations, and policies in a consistent manner between clients, services, and service providers.

The LME must monitor the application of clinical best practices and the use of the least restrictive and most cost-effective service option that appropriately addresses the clinical need for which the services were requested.

The results of utilization review decisions will be the shaping of service delivery to Medicaid recipients. Expected outcomes will reflect the following in aggregate:

- Reduction in hospitalization utilization.
- Reduction in child residential services.
- Reduction in out of state authorizations.
- When child residential services are required, the majority will be served in Therapeutic Foster Care family setting.

#### **1. Quality Improvement Plan**

The quality improvement plan must have a senior staff person responsible for the management, tracking, and reporting of quality improvement activities. There shall be evidence that senior management has reviewed and responded to results of the quality improvement activities.

#### **2. Clinical Care Criteria**

The LME shall have in place clinical care criteria related to best practices based on current treatment protocols and national standards (e.g., SAMHSA, American Psychiatric Association, etc.) for all major diagnoses and treatment modalities. These clinical care criteria must support appropriateness of care decisions by the LME and must be made available to DMA.

**3. Monitoring**

The LME is expected to monitor performance, timeliness, accuracy, provider relations and services, and system performances and to develop improvement plans when indicated to maintain compliance with requirements and best clinical practices. The plan shall be responsive to trends in performance that indicate a need for staff training, new policy development, and increased resources.

**B. Performance Measures for DMA****1. Treatment Patterns**

The mapping of diagnosis and previous treatment patterns to the appropriate authorization of community based services will be reviewed quarterly and targets included in contract standards with financial deductions for meeting the agreed upon objectives.

**2. Erroneous Decisions**

Erroneous decisions are defined as authorizations and denials that violate an officially promulgated federal or state regulation, policy or directive. In cases of erroneous decisions, the LME shall reimburse DMA for the total cost to DMA of the service(s) provided in error.

**3. Record Review**

On a quarterly basis, a random sample of cases will be selected by DMA from the LME's database and the LME shall send DMA copies of all documentation on the sample cases.

This review may include but is not limited to the following:

- If the LME approves/authorizes an admission/service based on an incorrect/invalid CON, the LME shall reimburse DMA for the payments made to the provider
- If the LME approves/authorizes a service based on incomplete information, i.e., lack of service orders or unsigned PCP, the LME shall reimburse DMA the total cost to DMA of the service(s) provided in error:
- In cases of erroneous decisions, the LME shall reimburse DMA the total cost to DMA of the service(s) provided in error.
- DMA reserves the right to sample as many services as it deems necessary to assure quality.

**4. Timeline for Review of Services**

Reviews of authorization requests shall be completed according to the timeline associated with the level of client acuity for services.

The performance standard shall be that 93% of reviews and related documents for authorization requests received that meet DMA's requirements for a complete request shall be completed and within the applicable Emergent/Urgent Residential or Inpatient Admissions, or Routine **turnaround time (TAT)** period. However, periods of time during which an authorization request is pended by LME for receipt of additional information from a provider, or other third party shall be excluded from the compliance calculation.

Penalties for non compliance with the 93% standard for Emergent/Urgent Residential or Inpatient Admissions, or Routine service requests shall be:

- 87% to 92% = 1% reduction in reimbursement of Invoice for services in the applicable TAT category
- 81% to 86% = 2% of Invoice for services in the applicable TAT category
- 75% to 80% = 4% of Invoice for services in the applicable TAT category
- 69% to 74% = 8% of Invoice for services in the applicable TAT category
- 63% to 68% = 12% of Invoice for services in the applicable TAT category
- 62% to 57% = 16% of Invoice for services in the applicable TAT category
- 51% to 56% = 20% of Invoice for services in the applicable TAT category
- 50% or less = 25% of Invoice for services in the applicable TAT category

The LME shall report weekly the average TAT for all reviews for all services in each TAT category (Emergent/Urgent Residential or Inpatient Admissions, or Routine). TAT reports shall be submitted to DMA attached to the monthly invoice and reflect that same time period.

**5. Review of Inpatient Services**

Telephone shall be used for inpatient hospital reviews. Telephone reviews shall generally be completed during the initial contact but shall in no event be completed more than four (4) business hours after the provider's initial contact with the LME. If the provider does not have the necessary information at the time of the initial telephone call, the LME shall complete the review within four (4) business hours after the LME receives the final information. The LME shall attain this standard of completing telephone reviews at least 97% or more. Compliance shall be monitored by DMA via audits. Any variations from these standards may result in a reduction in reimbursement of 1% per event per invoice.

**6. Electronic Submissions**

The LME must keep a log of all electronic submissions and shall acknowledge receipt of those electronic communications by return e-mail or fax, depending on method of submission.

**7. Notification**

Notification of the LME's approval shall be mailed to the appropriate parties within one (1) day to the service provider and to the recipient and/or his/her legal representative by trackable mail. The LME shall attain this standard of communicating notifications at least 93% or more. Compliance shall be monitored by DMA via LME reports and audits. Any variations from these standards may result in a reduction of 1% per event per invoice.

**8. Adverse Notification**

In the event of an adverse determination, notification of the LME's decision shall be mailed to the service provider and to the individual and/or his/her legal representative within one (1) day. DHHS standardized adverse decision notices with appeal rights shall be sent to the service provider and to the recipient and/or his/her legal representative by trackable mail. In situations of controversy regarding the receipt of this communication, the LME may be required by DMA to send authorization letters to specific providers or clients by trackable mail. Copies of adverse decisions shall be mailed to the provider (physician) and to DMA. The LME shall attain this standard of communicating adverse notifications at least 97% or more. Compliance shall be monitored by DMA via LME reporting, consumer or provider complaints and audits. Any variations from these standards may result in a reduction of 5% per event per invoice.

**9. Telephone Access**

The LME shall ensure there are a sufficient number of telephone lines and staff so that all calls can be answered within five (5) rings at least 93% of the time. DMA will sample this standard through random phone calls to the LME. Any variations from these standards may result in a reduction of 1% per event per invoice. The LME shall monitor and document this standard and report to DMA any deviations.

**10. Provider Relations**

The provider representative must be able to return all provider calls received Monday through Friday between 8:00 am and 6:00 pm within two (2) business days of receipt.

The LME shall monitor and document this response time and report to the Division any deviations greater than 93%. Any variations from the 93% standard may reduce the total invoice amount by up to 5%.

**11. Retrospective Reviews**

When retrospective record review is necessary, the record review shall be completed within sixty (60) days of receipt of the complete record. The LME shall follow DMA's procedure for requesting records. The provider's failure to furnish records for Medicaid paid services, following requests, will require the LME to send written notice to DMA Program Integrity Unit

**12. Quality Assurance Reviews**

Reviews shall be performed on Medicaid reimbursed services. These services will be individually reviewed by selecting a random sample of each service with the sample size selected by the nature of the service. Medical records must be requested for review.

If any problems are identified in this review process, the Behavioral Health and Program Integrity sections of DMA will be notified. The LME shall forward all relevant documentation to DMA concerning the problems identified. The two sections within DMA will then be responsible for any subsequent review or disposition of the problem.

This review process shall validate the information given at the time of authorization as reflected in the written medical documentation. The review shall also determine if a service provided meets medical necessity criteria for the appropriate level of care and appropriate quality of care, and the criteria was applied in a consistent manner.

Appeals and grievance procedures will apply if these reviews reveal the absence of medical necessity. Any denial of medical necessity must be made by the LME's physician consultants or licensed practicing psychologist and recipient appeal procedures will apply

**13. Audits**

The LME shall conduct internal random audits to assess inter-rater reliability of review staff and whether reviews have been conducted in full accordance with established procedures and criteria. Audit results shall be sent to DMA on a quarterly basis. Any audits that identify erroneous authorization or denials will be assessed at the next monthly invoice submission.

**14. Clinical Care Manager Certification**

Reviews conducted by a clinical care manager who is not licensed/certified in North Carolina will be subject to a reduction per event per invoice. In addition, if services are rendered inappropriately based on the review, the LME may be charged for the services billed.

## **XV. PRIVACY AND SECURITY**

**A. Records and Confidentiality**

The LME is required by state and federal law to maintain the confidentiality of all medical records. As a business associate, the LME is entitled to all of the service provider's medical records needed for this contract to which DMA itself is entitled under its contract to reimburse providers for services. Records received by the LME must be shared with only DMA or with other parties approved in writing by the individual or guardian and DMA.

**B. HIPAA Standards**

The LME must comply with all HIPAA standards according to the federal HIPAA Privacy and Security guidelines. Please refer to the summary found in <http://www.dhhs.gov/ocr/privacysummary.pdf> at [http://www.cms.hhs.gov/EducationMaterials/04\\_SecurityMaterials.asp](http://www.cms.hhs.gov/EducationMaterials/04_SecurityMaterials.asp).

**C. N.C. Identity Theft**

The LME must comply with all standards of the N.C. Identity Theft legislation (NCGS 132-1.10 and NCGS 75-65).

**D. Mishandled Protected Health Information**

The LME agrees to report to DMA (i) any use or disclosure of electronic protected health information or other protected health information not provided for by the Business Associate Agreement of which it becomes aware; and (ii) any security incident of which it becomes aware.

These incidents, as well as any “security breach” as defined by N.C. Identity Theft legislation, must be reported on the HIPAA Breach Report (see **Attachment N**). The completed form must be submitted as an attachment by e-mail to [DMA.Privacy.Official@ncmail.net](mailto:DMA.Privacy.Official@ncmail.net).

**E. Business Associate Requirements**

The LME will sign and abide by the standard DHHS Business Associate Agreement for HIPAA business associates. These requirements include

- The LME agrees to not use or disclose protected health information other than as permitted or required by the contract or as required by law.
- The LME agrees to use appropriate safeguards to prevent use or disclosure of the protected health information other than as provided for by this contract.
- The LME agrees to mitigate, to the extent practicable, any harmful effect that is known to the LME of a use or disclosure of protected health information by the LME in violation of the requirements of this contract.
- The LME agrees to report to DMA (i) any use or disclosure of electronic protected health information or other protected health information not provided for by the Business Associate Agreement of which it becomes aware; and (ii) any security incident of which it becomes aware.
- The LME agrees to ensure that an agent to whom it provides protected health information received from, or created or received by the LME on behalf of DMA agrees to the same restrictions and conditions that apply through this contract to the LME with respect to such information.

**XVI. CONFIDENTIALITY**

The LME is required by state and federal law to maintain the confidentiality of all medical records. The LME is entitled to the entire service provider’s medical records to which DMA itself is entitled under its Contract to reimburse providers for services. Records received by the LME must be shared only with DMA or with other parties approved in writing by the individual or guardian and DMA.

- The LME agrees to not use or disclose Protected Health Information other than as permitted or required by the contract or as required by law.
- The LME agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this contract.
- The LME agrees to mitigate, to the extent practicable, any harmful effect that is known to the LME of a use or disclosure of Protected Health Information by the LME in violation of the requirements of this contract.
- The LME agrees to report to DMA any use or disclosure of the Protected Health Information not provided for by this contract of which it becomes aware.
- The LME agrees to ensure that any agent to whom it provides Protected Health Information received from, or created or received by the LME on behalf of, DMA agrees to the same restrictions and conditions that apply through this contract to the LME with respect to such information.

- The LME agrees to provide access, at the request of DMA, to Protected Health Information in a designated record set to DMA or, as directed by DMA, to an individual in order to meet the requirements under 45 CFR 164.524.
- The LME agrees, at the request of DMA, to make any amendment(s) to Protected Health Information in a designated record set that DMA directs or agrees to pursuant to 45 CFR 164.526.
- Unless otherwise prohibited by law, the LME agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by the LME on behalf of, DMA available to DMA, or to the Secretary of the U.S. Department of Health and Human Services or his/her designee, in a time and manner designated by the Secretary of the U.S. Department of Health and Human Services, for purposes of the Secretary of the U.S. Department of Health and Human Services determining DMA's compliance with the Privacy Rule.
- The LME agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for DMA to respond to a request by an individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528, and to provide this information to DMA or an individual to permit such a response.

## **XVII. SECURITY**

### **A. Desktop and Laptop Computers**

All desktop and laptop computers must be secured to minimize unauthorized access and to reduce the opportunity for introduction of computer viruses.

- Each laptop's hard drive must be entirely encrypted such that if the laptop is lost or stolen, the information on the laptop would not be accessible by a non-owner.
- Each desktop and laptop must have an agency approved screen saver with a screen lock that engages after the keyboard and/or the mouse have been idle for a period of three (3) minutes or less.
- Each desktop and laptop must be turned off when not in use for an extended period of time or shall be powered down into a suspended status, except as specifically authorized by the agency security administrator.
- Anti-virus software must be installed on each desktop/laptop computer, and designated staff shall make certain that the desktop/laptop has the most current anti-virus software and appropriate patches installed.
- No modems or wireless communication devices shall be used in desktop or laptop computers, except as specifically authorized by the agency security administrator.
- No passwords shall be stored in clear text on desktop/laptop systems.
- Shared system-wide applications may not contain stored passwords that enable applications to be run without entry of the password each time the application is launched.
- Wireless systems must be approved by the agency security administrator and must have encryption capabilities enabled.

- Desktops/laptops that contain confidential information must be configured so that they cannot be booted from a floppy disk or a CD ROM.
- Critical data files must be backed up, and if confidential data is backed up, the backup media must receive appropriate security.
- Only standard approved software shall be installed on the desktop/laptop with any exceptions being pre-approved by the agency management and reviewed by the security administrator.
- Default settings for applications such as e-mail, calendar, and Internet access tools must be set to support a secure environment.
- Security audits must be performed internally on a regular basis to ensure compliance with the standard requirements.

**B. Electronic Mail**

The LME must send all PA and UM/UR related e-mails using a secured, encryption enabled e-mail method, such as ZixMail.

To reduce unauthorized access to (e-mail) systems all e-mail services must adhere to the security requirements G.S. §147-33.110.

**C. Configuration**

- All services and operations must be disabled except those that are expressly permitted (e.g., Web based mail, FTP, remote administration) and only the minimal Internet services required shall be installed.
- Default accounts and groups must be disabled or removed.
- The service banner must not report the mail server and operating system type and version.
- The mail server must be configured to use encrypted authentication of passwords or other authentication data.

**D. Firewall/Mail Relay**

The mail server must be protected by a firewall that controls all traffic between the Internet and the server.

- Incoming and outgoing messages must be scanned for viruses at the firewall or mail relay. If attachments are allowed on the e-mail service, the mail server administrator must filter potentially dangerous attachment types (e.g., .vbs, .ws, .wsc file extensions) at the mail server or mail gateway and conduct virus scans on allowed file types.
- The firewall (or router that is acting as a firewall) must block all access to the mail server from the Internet except those ports that are required to operate the e-mail server.

**E. Intrusion Detection System (IDS)/Intrusion Prevention System (IPS)**

- IDS/IPS must monitor network traffic to and from the mail server and must monitor changes to critical files on the mail server (host-based or file-integrity checker).
- A firewall, in conjunction with IDS/IPS, must block IP addresses or subnets that the IDS/IPS reports are attacking the organizational network.
- IDS/IPS must be configured to log events and the logs must be maintained for at least three months.
- IDS/IPS must be updated with new attack signatures at least weekly.

**F. Other Security Requirements**

- Secure worksite – ID badges, restrictive entry, and account for people coming and going after hours via a signed logbook. Use of main door only by the workforce. Use of back doors shall be restricted to authorized personnel only.
- Data at rest – if the LME has a server room, it must be locked with restricted entry. A log must be maintained and signed by each individual entering the room, showing the date and time of each entry to the server room.
- Portable data devices – if data devices are portable, they may not be removed from the premises unless encrypted (laptop, thumb drive, etc.).
- Data in transit – web browsers with on line access must be data encrypted with SSL, FTP files must be by secure ftp, data mailed on CDs must be encrypted and labeled as confidential.
- Passwords must be used on all applications.
- Passwords may not be shared, except with authorized support technicians
- All workforce must be trained to know the rules for HIPAA and NC Identity Theft. Statements must be signed indicating that they have received this training, understand it, and accept responsibility.
- All workforce must be trained to know the rules for HIPAA and NC Identity Theft. Statements must be signed indicating that they have received this training, understand it, and accept responsibility.

**XVIII. STATEWIDE ARCHITECTURE**

All systems must comply with the North Carolina statewide architecture requirements. Policies can be found at <http://www.ncsta.gov/>.

**XIX. DISASTER RECOVERY**

The LME must have a documented Disaster Recovery plan that has been implemented and, at a minimum, is tested annually. It must include, but not exclusively, the following items:

- Daily backups of software and production data files on all servers on both host and local area network systems.
- A verification and audit program must be used to confirm that the system backups are complete and accurate.
- If tapes are used for system backups, they must be rotated regularly to ensure the physical integrity of the tapes and to minimize tape parity error problems.
- Backup files transported offsite at a minimum of a twice-per-week schedule.
- Backup software and data maintained at an offsite location at least 50 km (30 mi.) from the primary site.
- Offsite location that has been tested to replicate the current working environment to provide full recovery within a period of 24 hours using the backups described above.
- Personnel trained to service beneficiaries, with controlled access to the clients' data, must either be present or have access to the backup site.
- Data traffic automatically rerouted to the backup site in the event of a disaster at the primary site.

- In case of a disruption in a service center, all telephone calls are to be automatically rerouted to the backup service center or alternate site.
- Communication plan, succession plan, and escalation process in the event of a disaster.
- Training of the workforce to assure familiarity with the plan.

## XX. DATA PROCESSING

### A. Overview

While each LME will have their own unique automated utilization management system, it is necessary that these systems capture certain required information and standard elements. This is needed to ensure consistency of reporting statewide. Each LME will send a daily (Prior Approval) PA file via FTP to the Fiscal Agent. It will include prior authorization information and reporting information. Each LME will submit to the Fiscal Agent via FTP a weekly summary report which will contain summary information that is not captured on the daily FTP file but is needed for reporting purposes. Each of these files is explained in more detail below. DMA will be the final arbitrator of any disputes about the specifications and methods for Fiscal Agent interface by LME.

In situations where issues arise, DMA, DIRM and the Fiscal Agent staff may evaluate the LME's data system to identify issues or barriers in data transfer. Joint assessment and problem-solving will occur to assure efficient and effective data system interface. Appropriate LME personnel will be engaged to meet this objective and may include both central operations and local data systems staff.

DMA retains privilege to access needed LME technical staff and IT systems according to the circumstances and situations presented for operations of these requirements.

DMA will provide written notification to the LME of all system change requirements no less than sixty (60) days prior to the effective date of operation.

### B. Prior Approval Process

In order for a provider to be paid for a service that requires prior approval, there must be an approved prior approval record on the Fiscal Agent's PA master file.

#### 1. Daily PA File

For LMEs to create a prior approval record on the PA master file, the LME must FTP this information by 5:00 p.m. daily to the Fiscal Agent in a fixed length flat file with variable length fields. Refer to **Attachment O** for the *LME PA Authorization Inbound File Layout*.

The file layout indicates whether a field is required or optional. Also there is a column that defines each field.

**Note:** More information on the actual creation and processing of these files will be shared at a later date.

When the Fiscal Agent receives the daily PA file, the Fiscal Agent's system validates the data before loading it to the PA master file. An accept and reject file will be sent via secure FTP to the LME's mailbox. The LME will be responsible for retrieving the files.

Refer to **Attachment P** for a copy of the *LME PA Authorization Outbound File Layout*.

Any errors that are found will be sent back to the LME on the Reject file with an error code which identifies the error. Refer to **Attachment Q** for the *PA Authorizations Error Codes*. The reject file will be available for the LME to pick up the next business day.

The LME must work the reject file within three (3) business days and resubmit the prior approval request. It is critical that this be accomplished timely. If the provider files the claim before the rejected prior approval is resubmitted, the claim will deny for no PA on file.

Any variations will be processed directly with the fiscal vendor then referred to DMA for problem-solving as necessary. DMA staff will have full access to LME's IT system as needed for this purpose.

The LME must ensure that all transmissions are cataloged and maintained for the life of the Contract.

## **2. Overlapping Authorization Dates**

Prior approvals with overlapping dates are not allowed. The LME must ensure that these are not sent to the Fiscal Agent on the PA file.

**Note:** Information on how to submit these PA requests to the Fiscal Agent will be provided at a later date.

## **3. Summary PA File**

The LME must send summary PA data to the Fiscal Agent on a weekly basis via secure FTP in a standard file format. The file must be sent by 5:00 p.m. on the first business day following the last business day of the week. Refer to **Attachment R** for the *Weekly Summary Inbound File Layout*.

When the Fiscal Agent receives the PA Summary data file, the Fiscal Agent's system validates the data. A reject file will be sent via secure FTP to the LME the next business day. Refer to **Attachment S** for a copy of the *Weekly Summary Outbound File Layout*.

Any errors that are found will be sent back to the LME on the Summary Reject file with an error code which identifies the error. Refer to **Attachment T** for a list of the *Weekly Summary Error Codes*.

**C. Data Collection**

Information obtained in each paper, telephone, and electronic review performed by the LME must be documented by the reviewer and entered into the LME's database. All documentation must be available in an electronic record. It is the responsibility of the reviewer of record to complete the required data elements before a review is completed and a recommendation is made to DMA.

Compliance will be audited quarterly by the LME's Director of Information Management Systems. All results of internal audits must be submitted to DMA on a quarterly basis. The audits must, at a minimum, address issues listed in the Performance Standards as well as internal continuous quality control measures adopted by the LME.

**D. Front-end Editing**

In order to ensure the highest degree of accuracy of PA data into the DMA PA master file, there are certain front end edits that need to be implemented at the onset of PA data entry by the LME. If any of the edits fail, the PA should not be allowed to progress further through the system. The LME needs to provide edits including but not limited to the following information:

- Recipient MID, DOB, Name as compared to the Eligibility file.
- Provider Medicaid eligibility and service eligibility as compared to information on the Provider file.
- Valid diagnosis code.
- Not a duplicate.
- No overlapping dates with a current authorizations for the same service level.

**Note:** More specific information will be provided at a later date.

**E. Data Ownership**

The LME agrees that data provided by DMA to the LME is owned by DMA and shall only be used for the sole purpose of supporting the statement of work of these requirements. All data created in any form as part of these requirements shall become the property of DMA and shall be accessible by DMA at any time. All data associated with this Contract shall be transferred to and accepted by DMA prior to final payment to LME at the end of the Contract. Under no circumstances shall the LME share data with any other entity without prior written authorization by the DMA Contract Administrator or designee.

**XXI. REPORTING**

The LME must provide reports of collected data that will assist DMA in managing its system of care for recipients with behavioral health, developmental disability, and substance abuse treatment needs. Data may be requested by DMA in a frequency, form, and format necessary to meet its operational needs.

Data must be able to be transferred electronically and developed in Microsoft Access or Excel.

**A. Ad Hoc Reports**

Ad hoc reports will be requested by DMA on an as needed basis. There will be instances where the report information will be needed the same day it is requested. Typically, ad hoc reports will be required within 1 to 2 days of the request.

**B. Quarterly Reports****1. Quality of Care Incident Summary Report**

The LME must submit a summary report (see **Attachment U**) on a quarterly basis indicating the disposition of the quality of care complaints that were reported to DMA (see **Section VIII.G.2.**).

**2. Staff Qualification Verification**

Refer to **Section IV.E.** for information on staff qualification verification.

**3. Significant Trends**

The LME must report to DMA any significant trends from the previous quarter and other historical data that may facilitate the provision of appropriate, cost-effective service to recipients with mental health, substance abuse, or developmental disability treatment needs (see **Section V.D.**).

**4. Internal Compliance Audits**

Results of must be submitted to DMA (see **Section XX.C.**).

**C. Monthly Report on Adverse Determination Letter Audit**

The LME must submit a monthly report documenting the results of audits on the accuracy and completeness of notifications to recipients on service requests that resulted in an adverse action. The report must indicate how the errors identified in the audit were resolved (see **Section XI.E.**).

**XXII. INVOICING****A. Submitting Invoices**

The LME must submit invoices on a monthly basis. The invoice must document all LME activities from the previous month. The invoice must be submitted to DMA within thirty (30) calendar days following the end of each month. The invoice must be in good business form, signed and dated by a responsible company official, and include the correct purchase order number. Refer to **Attachment V** for a copy of the report format.

The invoice must include the following information:

- The date range for the invoice.
- The quantity of each type of review.
- The rate for each type of review.
- The cost for each type of review and the total cost for all reviews.
- LME contact information including name, e-mail address, and phone numbers in case of inquiries regarding the initial invoice or supporting documentation.

- The invoice shall be accompanied by two (2) copies of documentation supporting the invoice. The supporting documentation must be electronic in nature and contained on Read Only computer media, CD, or DVD data disk(s).
- The totals for services and cost contained in the supporting documentation must equal the cost and number of services submitted in the invoice.
- The support data must be in Microsoft Excel format and password protected for personal health information.

Invoices are sent by e-mail and on paper to the DMA Contract Manager and to the designated representative of DMA's Contracts Monitoring Section. The invoice must be received and signed for by DMA's Contract Manager or his/her designated representative.

All monthly invoices shall be directed to:

Chief of Behavioral Health Services  
Division of Medical Assistance  
1985 Umstead Drive, Kirby Building  
2501 Mail Service Center  
Raleigh NC 27699-2501  
Phone (919) 855-4260  
Fax (919) 733-2796

Contract Administrator  
Division of Medical Assistance  
3101 Industrial Drive, Suite 205  
Raleigh NC 27609

DMA will review the invoice and documentation. Every effort will be made to pay the invoice, less any deductions, net thirty (30) days from the date the invoice arrives.

DMA's invoice reviewers shall be permitted, at their discretion, to ask for and review additional documentation. DMA's invoice reviewers will be permitted to review documentation and/or computer databases at DMA's offices or at the LME's offices, or elsewhere as deemed appropriate by DMA.

The LME must submit a final invoice within one hundred twenty (120) calendar days of the end of the month invoiced. The final invoice and accompanying support data must have all duplicate billing removed and other errors as noted. The invoice must be in good business form, signed and dated by a responsible company official, and include the correct purchase order number. The final invoice must include the following information:

- LME contact information including name, e-mail address, and phone numbers in case of inquiries regarding the initial invoice or supporting documentation.
- The invoice shall be accompanied by two (2) copies of documentation supporting the invoice. The supporting documentation must be electronic in nature and contained on Read Only computer media, CD, or DVD data disk(s).
- The totals for services and cost contained in the supporting documentation must equal the cost and number of services submitted in the invoice.

DMA will make every effort to complete its review of the final invoice and supporting data within thirty (30) days of receipt, and send the invoice on for payment.

Invoices and supporting reports dates must be congruous. The Performance report must match dates and data from invoices. Weekly documents may be provided to DMA but invoices must be modified and reissued for changes.

**B. Issue Resolution**

DMA will attempt to resolve any questions charges with the designated contact person. Unresolved questions of individual charges that do not appear to be appropriate and are not yet resolved, will be listed and submitted to the LME for response.

Issues related to invoice charges may be addressed by the LME as follows:

- In writing, submit additional documentation in support of the questioned charges.
- In writing, ask to withdraw the charges and reduce the invoice by the amount of the questioned charges.

**C. Reduction of Reimbursement to LME Based on Performance**

The LME shall submit performance reports attached to the monthly invoice for the same period of time. The LME may deduct the amounts warranted by the performance reports with explanation of all adjustments incorporated into the invoice. DMA will analyze the reports and inform the LME of any tentative penalty by the 30<sup>th</sup> day of that same month.

If there is a disagreement in the application of deductions, DMA will schedule an informal meeting within fifteen (15) days to discuss any contested tentative penalty. DMA will issue its final decision with fifteen (15) days of the conclusion of the informal hearing.

Performance targets based upon service outcomes are assessed. Any payments, withholding or deductions will be assessed within sixty (60) days following receipt of data reports and may be applied retroactively to the previous 12-month aggregate payments.

**D. Payment**

Payment is by transaction (authorized plus denied) via monthly invoice to DMA. Payment is based on unit price per review.

Payment is received after invoice is reconciled and audited. DMA will pay only those items that are verified and approved on the final invoice. All charges that are unsupported or not verifiable will be deducted from the invoice.

## XXIII. OTHER REQUIREMENTS

### A. Meetings

At DMA's request, the LME shall meet with DMA at the DMA's offices in Raleigh, North Carolina or another mutually agreeable site to discuss problems encountered by the LME, to review progress, and/or to discuss approaches to problems. Anticipated frequency of meetings/conference calls is monthly.

### B. Contract Administrator

The LME shall designate a single Contract Administrator to be the primary contact with DMA, for all issues regarding this Contract. The LME's Contract Administrator, or coverage designee during absences, shall be available by phone, facsimile, or e-mail at any time during business hours, 8:00 a.m. to 6:00 p.m.

### C. Travel

The LME shall be responsible for all travel expenses incurred by the LME.

### D. Testing

The LME must participate in extensive testing of the PA file and the summary file for implementation as well as any time there are changes to either of these files.

The LME must allow DMA to review testing of their internal system changes required to meet the standard requirements for reporting.

### E. Record Release

All records must be released as requested to DMA and its agents including, but not limited to:

- Medicaid Investigation Unit
- Attorneys General
- Office of Inspector General
- Centers for Medicare and Medicaid Services

### F. Provider Training

The LME shall be responsible for training service providers on its prior approval policies and procedures and on clinical care criteria to assure effective and efficient request for services. The LME is responsible for ongoing training and technical assistance to service providers on both an individual and group basis to assure effective performance and continued access to services for Medicaid recipients.